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ABSTRACT

This annual report presents data on the health status and needs of American children from infancy through adolescence. The report's first section gives general population data, providing context for sections two and three, which present data on health status and service utilization for American children. The fourth section contains state-specific data on infant health which show the variability among states on basic health measures. The data indicate that gaps exist in primary care which could save the lives or improve the health of millions of children. Almost half of American children were not receiving immunizations at the recommended ages. Almost 28% of children aged 5-17 had not had a dental visit in the previous year. From ages 1-20, children and adolescents are more likely to die from injury than from any other cause, in spite of simple precautions, such as wearing bicycle helmets, a practice that could have prevented many injuries. Data indicate that greater efforts should be made to combat abuse, neglect, drugs, and violence in the family. School-based and school-linked services are both promising ways to make better health services and information available to children and their families. Health care reform, providing universal health insurance coverage, help bring American children and their families appropriate health promotion, disease prevention, disease treatment, and chronic care. (Contains 46 references.) (CC)

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CHILD HEALTH USA '93

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HEALTH & HUMAN SERVICES
Public Health Service
Health Resources and Services Administration

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PREFACE

Child Health USA '93 is the fifth annual report on the health status and service needs of America's children provided in this format. The publication brings together data from various sources and presents in graphs, charts, and simple text the sentinel measures by which we can assess how well our children are faring. We can track and take pride in our accomplishments in improving the health status of children. But more importantly, we can identify the new and recurring threats to our children's health and measure our progress in meeting those challenges.

This booklet presents information on the health of children in various developmental stages. It measures children's health in accordance with the *World Health Organization's* vision of "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity." Although this booklet can provide only a selection of data, the indicators presented are significant for an appreciation of those factors which critically affect health and development throughout the continuum of childhood.

Child Health USA '93 is divided into four sections. The first provides general population data to give the context for the measures of health status and services utilization which follow in sections two and three, respectively. Data in sections two and three are presented for broad developmental stages of *infancy*, *childhood*, and *adolescence*. The final section contains state-specific data on infant health which show the variability among states on basic health measures.

The Bureau is indebted to the National Center for Health Statistics for its continued collaboration in producing this data book. Specific sources of information presented in the publication are provided in references beginning on page 54.

We hope that this annual look at the health status of our nation's children will inform agencies and individuals – in both the public and private sectors – about the direction in which they must move to more effectively meet children's health needs in this current decade.

Maternal and Child Health Bureau
Health Resources and Services
Administration

INTRODUCTION

. . . healthy children are more than the result of the health care services they receive. Healthy children are the products of nurturing families who provide good diets, safe homes, good examples, and emotional support for their children's growth and development.

Improving the health and well-being of children is among the nation's most important goals. Health care reform that provides universal health insurance coverage for all Americans, particularly children, millions of whom now have no health insurance protection, will bring them the benefits of health promotion, disease prevention, developmental treatment, and chronic care. We anticipate that improvements in the health status of children will be seen when a more rational allocation of health resources occurs.

For decades, the Maternal and Child Health Bureau has been hard at work identifying the services that can prevent disease and disability, testing effective treatments and interventions, and creating family-centered, community-based systems of care. Removing the financial barriers to such services through health care reform is an essential first step. Improved access, however, must be accompanied by appropriate services that address the psychological, social, functional, educational, developmental, and family support needs of children and their families.

The periodic assessment of a child's growth and development must be available to all. Early detection and intervention often provide the greatest benefits at the lowest cost. For example, screening for hearing loss has traditionally been carried out as toddlers approach their third birthday, when the development of speech may have already been significantly impaired. In 1993, based in part on MCHB-supported research, an NIH consensus conference recommended screening newborns for hearing loss before the babies leave the hospital. Such early detection presents possibilities for correcting the problem in some children; in others, an opportunity to adapt so that hearing loss will not adversely affect a child's other developing senses. Transforming the benefits identified through research into everyday health care will continue to challenge us as a nation.

Gaps exist in primary care which might save the lives or improve the health of millions of our children. For example, almost half the children in America are not receiving immunizations for a number of contagious diseases at the ages when it is recommended that the vaccines be administered. Only an outbreak of measles in the period 1989-1991 alerted Americans to the problem.

From age one to twenty, children and adolescents are more likely to die from injury than from any other cause. Many of these injuries could have been prevented. Children who wear bicycle

helmets are protected from head injury. Seat belts save lives. We must actively choose to use safety measures such as these so that our children can derive protection from them.

Abuse and neglect are destroying the sanctity and security of the family. Drugs and violence are killing children and adolescents and destroying families. When communicable diseases were the dominant killers of our children, we worked on many fronts to protect their health: in the laboratory, to isolate the causes of disease and develop effective therapies; in a care setting, to treat the symptoms and boost the body's defense mechanisms; in the community, to improve sanitation and safety and reduce the spread of infection. Similar efforts must be made to combat abuse and neglect, injury, drugs, and violence.

As we work to eliminate the causes of violence and injury to our children, we must do more to protect them. We must teach them and their families about the risks that confront them and about the choices that lead to good health, and reinforce their self-esteem so they can intelligently confront potentially harmful peer and societal pressures.

School-based and school-linked health services are both promising ways to make health care services accessible to children and their families. These services must be coordinated with all health services and other educational and social programs that support and enhance the health and well-being of families.

Today, healthy children are more than the result of the health care services they receive. Healthy children are the products of nurturing families which provide nourishing diets, safe homes, good examples, and emotional support for their children's growth and development.

Children flourish when the communities in which they live value them enough to dedicate resources to their well-being. We must engage and protect the interests and energies of our children through quality education, safe streets and environments, and recreational activities.

Comprehensive health care coverage for those in society who are among the most needy and least able to fend for themselves will help secure their well-being and America's future as well.

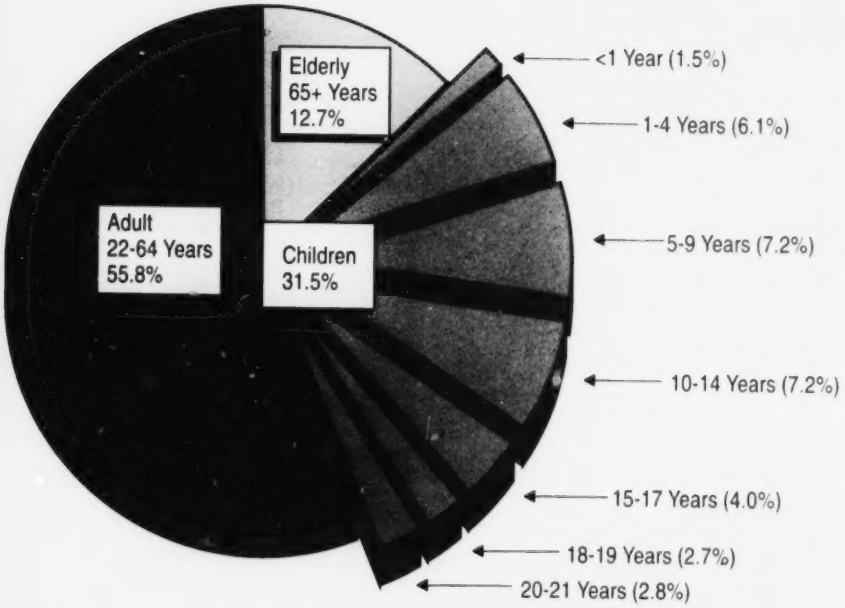
POPULATION CHARACTERISTICS

There are several sociodemographic characteristics that are used to describe the maternal and child population (e.g., race, age, poverty status). At the national, state, and local levels, policy makers use this information to systematically address the health problems of the mothers and children they serve and to develop programs and allocate resources that best meet their needs.

We have provided information on the following population characteristics because of their potential impact on program development in maternal and child health: population distribution by age, poverty status, living arrangements, child care, and school dropout rates.

U.S. Resident Population by Age Group: 1993

Source (I.1): U.S. Bureau of the Census



POPULATION OF CHILDREN

In 1993, there were almost 81 million children through the age of 21 in the United States, representing 31.5% of the total population.

Between 1980 and 1993, there was an 18.6% increase in the number of children under 5 years of age.

Although there were approximately 25 million more children younger than 22 in 1993 than in 1950, this age group is declining relative to other age groups in the population.

In 1993, persons aged 65 and over represented 12.7% of the total population. By the year 2000, this group is expected to increase by 8.1%, whereas the child population is expected to increase by 6.9%.

CHILDREN IN POVERTY

In 1991, there were 13.7 million related children under 18 years of age living in poverty. This age group contains 38.3% of all the nation's poor.

Black or Hispanic children are between 2 and 3 times more likely to live in poverty than are white children.

Between 1980 and 1991, the number of children living in poverty increased by almost 2.5 million. In contrast, the number of persons 65 years of age and over living in poverty decreased by 0.1 million.

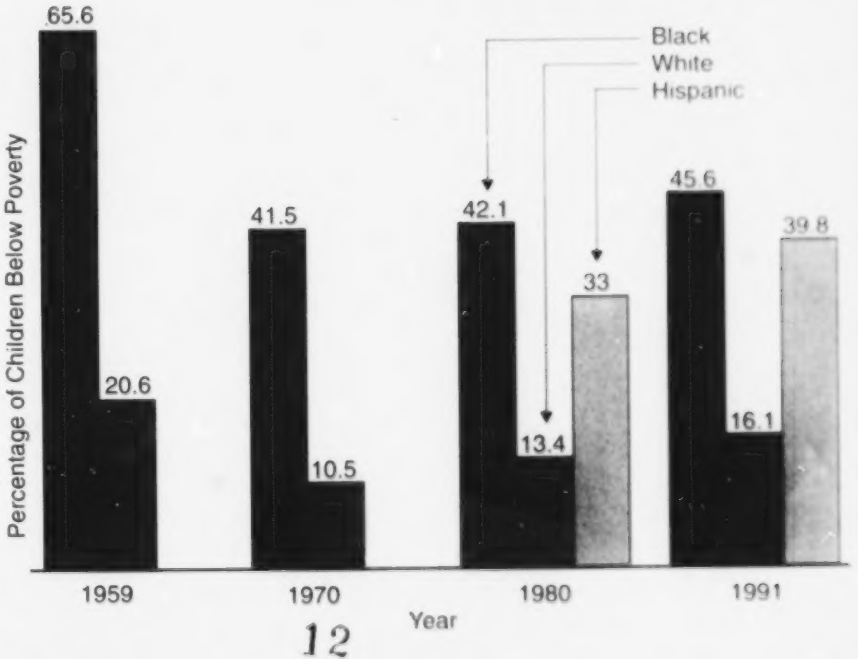
In 1991, a family of four was considered to be living in poverty if its annual income was below $13,924.

Note: Hispanic data are not available prior to 1973.

* Related children in a family include householder's own children and all other children in the household who are related to the householder by blood, marriage, or adoption.

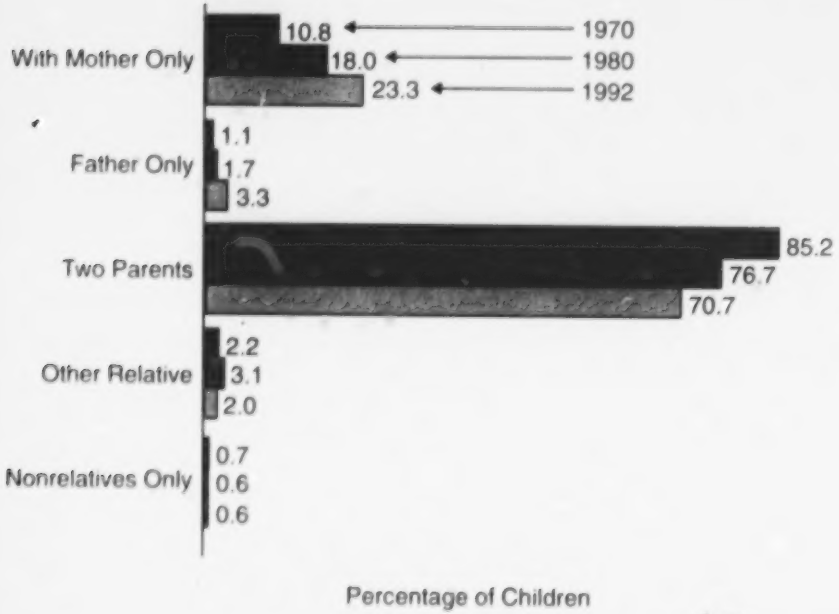
Related Children Under 18 Years of Age* in Families Below Poverty: 1991

Source (12): U.S. Bureau of the Census



Living Arrangements of Children Under 18 Years of Age: 1970-1992

Source (13): U.S. Bureau of the Census



FAMILY COMPOSITION

In 1992, 17.6 million children lived in families with only one parent. This group represented 26.6% of children younger than 18 years of age.

Since 1970, the percentage of children living with single parents has more than doubled, from 11.9% to 26.6%. A rise in the divorce rate and the number of unmarried parents have contributed to this increase.

In 1992, the vast majority of single parent families consisted of children living with their mothers. Of children living with only one parent, the proportion living with a single father has grown from 9.1% in 1970 to 12.4% in 1992.

White children are less likely to be living with one parent than black or Hispanic children. The proportions living with one parent in 1992 were 21% for white children, 32% for Hispanic children, and 57% for black children.

Nearly 66% of black children and 66% of Hispanic children who live with a single mother are below the poverty level.

Note: A parent may be a stepparent or parent by adoption.

WORKING MOTHERS

In 1993, almost 60% of all mothers with preschool-aged children (younger than 6 years) were in the labor force, reflecting a twofold increase since 1970.

Presently, there are about 9.6 million working women with preschool-aged children.

Currently, about 11.5 million children younger than 6 and 27.1 million children ages 6 through 17 have mothers in the labor force.

CHILD CARE

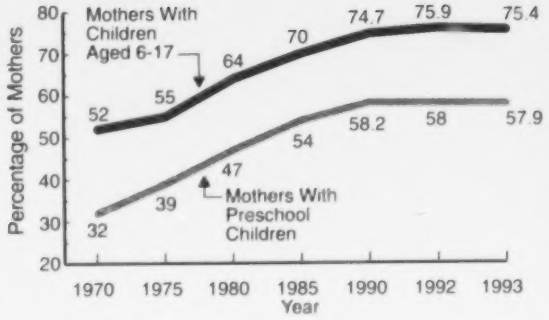
In 1991, almost one-fourth of children younger than 5 (2.4 million) whose mothers worked outside of the home spent their days in nonresidential day care centers.

Since 1988, the number of children being cared for by fathers has increased to about 1 child in 5.

Women who work full time tend to use day care centers while women who work part time are more likely to use in-home care.

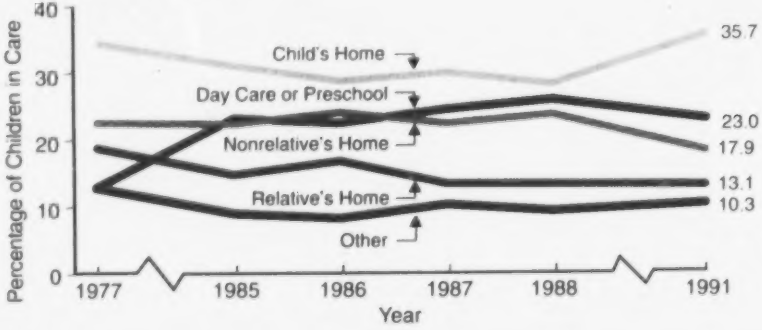
Mothers in the Labor Force: 1970-1993

Source (I.4): U.S. Bureau of Labor Statistics



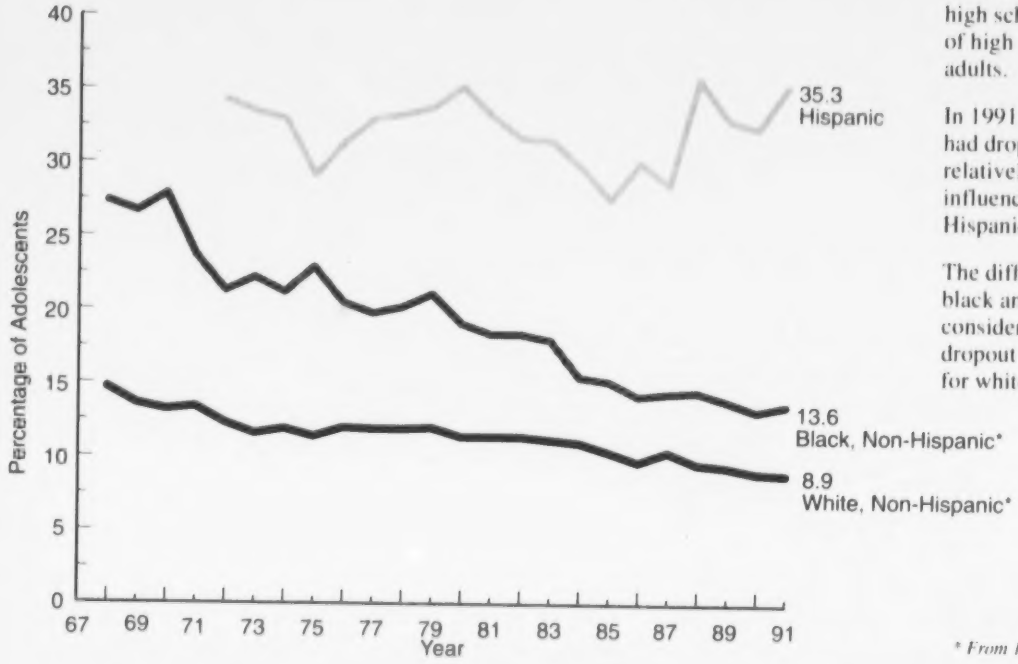
Place of Care for Preschool-Aged Children: 1977-1991

Source (I.5): U.S. Bureau of the Census



School Dropout Status for Adolescents Ages 16-24 by Race/Ethnicity: 1968-1991

Source (I.6): U.S. Bureau of the Census



SCHOOL DROPOUTS

In 1991, 3.8 million 16- to 24-year-olds were out of school and had not completed high school. Those who have dropped out of high school represent over 12% of young adults.

In 1991, more than 35% of young Hispanics had dropped out of high school. This relatively high percentage may have been influenced by high immigration rates of Hispanics in recent years.

The difference between the dropout rates of black and white young adults has narrowed considerably in the last 20 years, as the dropout rate decreased faster for blacks than for whites.

** From 1968-71, includes persons of Hispanic origin.*

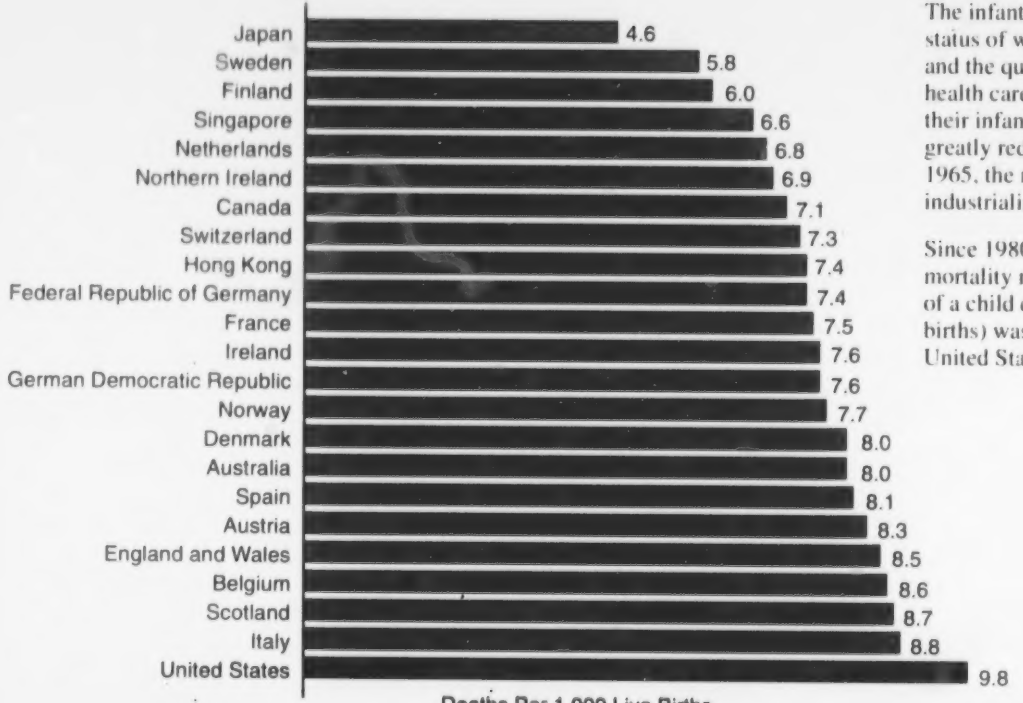
HEALTH STATUS

The measurement of the health status of our children is important because it enables us to assess the impact of past and current programs and to plan future efforts. The health status indicators in this section are based on vital statistics and national surveys. Although the sample surveys are limited in size, the data are representative of the populations needing maternal and child health services.

Health status indicators used in this section are presented by age group: infant, child, and adolescent. This categorization is intended to reflect the changing needs of children as they grow and develop.

Comparison of National Infant Mortality Rates: 1989

Source (II 1): National Center for Health Statistics



COMPARISON OF NATIONAL INFANT MORTALITY RATES

The infant mortality rate reflects the health status of women before and during pregnancy and the quality of risk-appropriate primary health care accessible to pregnant women and their infants. Although the United States has greatly reduced its infant mortality rate since 1965, the nation ranks lower than 22 other industrialized countries.

Since 1980, Japan has had the lowest infant mortality rate in the world. In 1989, the risk of a child dying in infancy (4.6 per 1,000 live births) was less than half that observed in the United States (9.8 per 1,000 live births).

INFANT MORTALITY

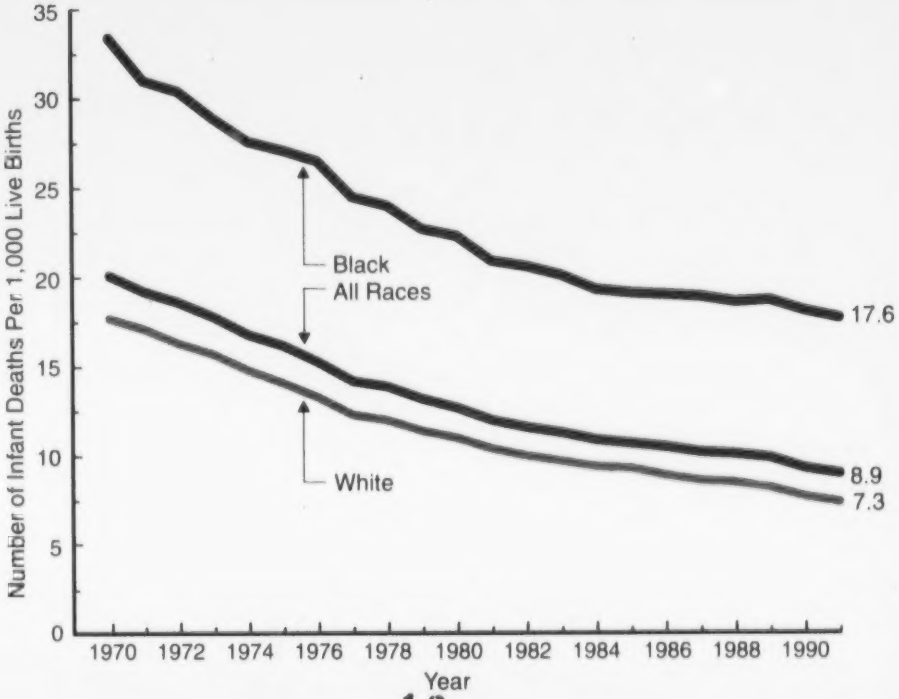
In 1991, 36,766 infants died before their first birthday. The infant mortality rate was 8.9 deaths per 1,000 live births. This figure represents a decline of 3% from the rate of 9.2 for the previous year.

The rapid decline in infant mortality, which began in the mid 1960s, slowed for both blacks and whites during the 1980s.

The infant mortality rate for black infants was 2.4 times the rate for white infants.

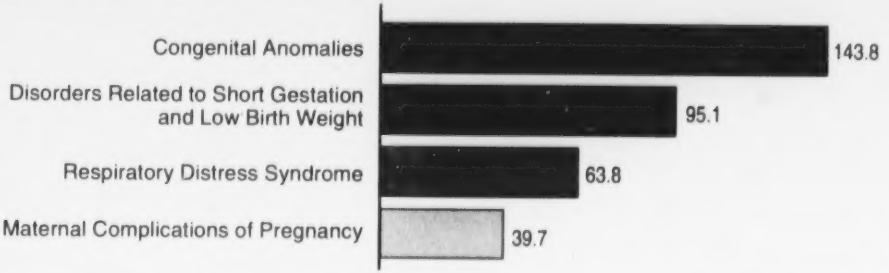
U.S. Infant Mortality Rates by Race of Mother: 1970 - 1991

Source (II.2): National Center for Health Statistics



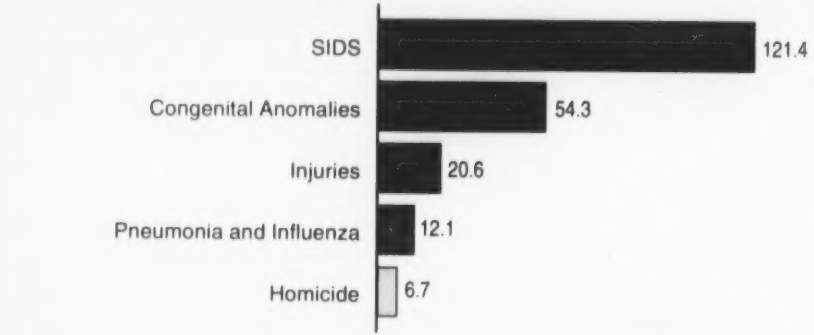
Leading Causes of Neonatal Mortality: 1990

Source (II.3): National Center for Health Statistics



Leading Causes of Postneonatal Mortality: 1990

Source (II.3): National Center for Health Statistics



NEONATAL AND POSTNEONATAL MORTALITY

Neonatal

In 1990, 24,309 infants younger than 28 days died; the neonatal mortality rate was 585 deaths per 100,000 live births.

Postneonatal

In 1990, 14,042 infants 28 days to one year old died; the postneonatal mortality rate was 338 deaths per 100,000 live births.

Of the five leading causes of postneonatal death, injuries may clearly be prevented with appropriate intervention.

Homicide, the sixth leading cause of postneonatal death in 1989, became the fifth leading cause in 1990, at 6.7 deaths per 100,000 live births.

Between 1960 and 1990, the postneonatal mortality rate decreased faster for black infants than for white infants.

MATERNAL MORTALITY

During the past several decades, there has been a dramatic decrease in maternal mortality in the United States. Since 1980, however, the rate of decline has slowed.

In 1991, there were 323 maternal deaths which resulted from complications of pregnancy, childbirth, or the postpartum period.

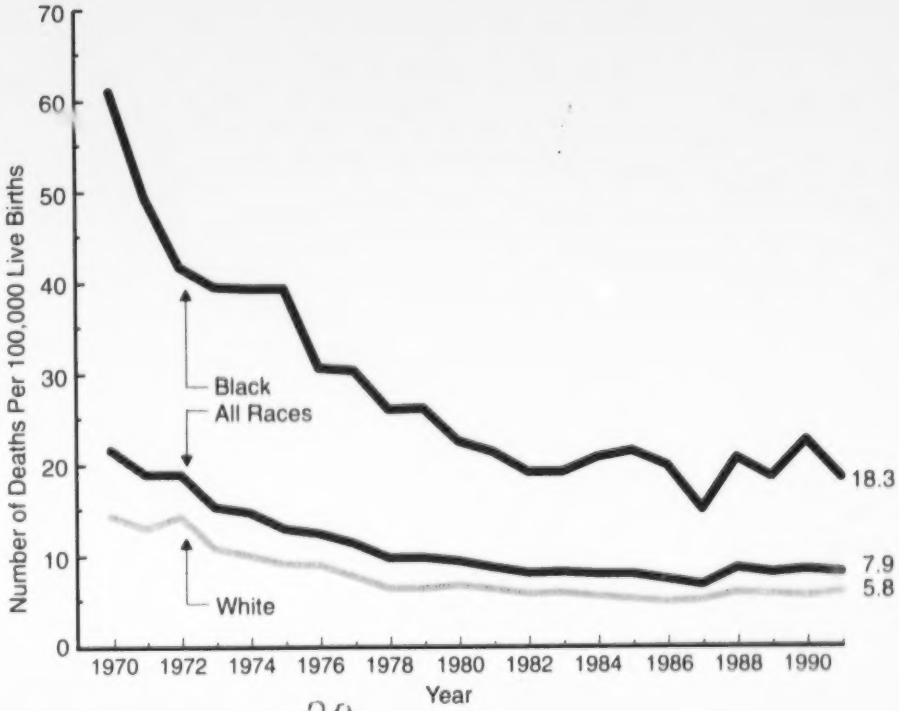
The maternal mortality rate for black women (18.3 per 100,000 live births) is more than three times the rate for white women (5.8 per 100,000 live births).

Regardless of race, the risk of maternal death increases for women over 30; women 35-39 years old have more than twice the risk of those aged 20-24 years.

Note: 1970-1988 data based on race of child; 1989-1991 data based on race of mother.

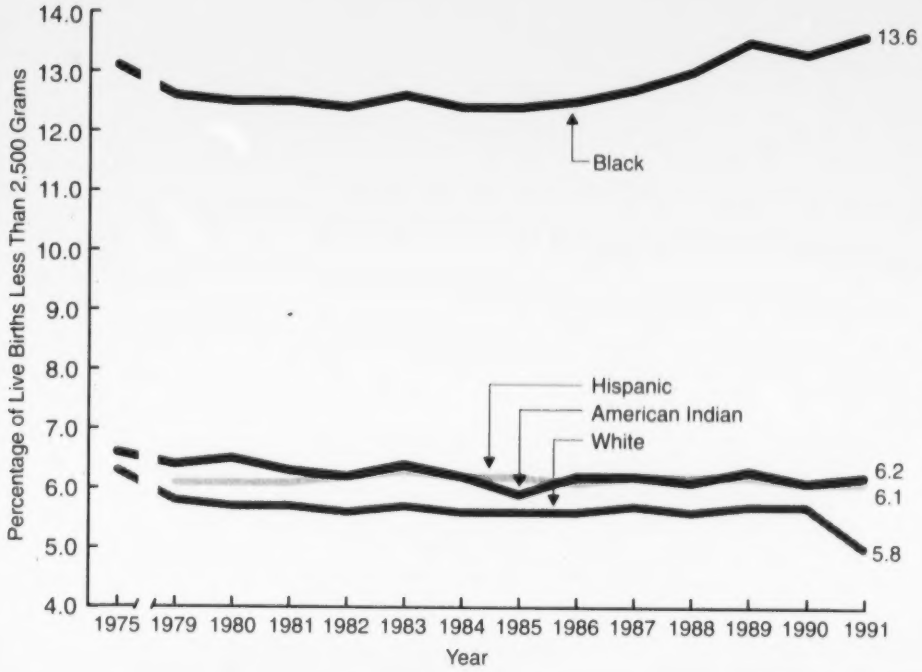
Maternal Mortality Rates by Race: 1970 - 1991

Source (II.4): National Center for Health Statistics



Percentage of Low Birth Weight Infants by Race: 1975-1991

Source (II.5): National Center for Health Statistics



LOW BIRTH WEIGHT

In 1991, 292,230 babies (7.1% of all live births) were of low birth weight, weighing less than 2,500 grams, or 5.5 pounds, at birth.

The percentage of low birth weight births did not decrease between 1980 and 1991, but rose slightly from 6.8% to 7.1%.

Low birth weight is the factor most closely associated with neonatal mortality. Low birth weight infants are more likely to experience long-term disabilities or to die during the first year of life than are infants of normal weight.

Social factors associated with increased risk of low birth weight include poverty, low level of educational attainment, unmarried status, and minority status.

Note: 1975-1988 data based on race of child; 1989-1991 data based on race of mother.

CONGENITAL ANOMALIES

Down Syndrome

Down syndrome is one of the leading causes of mental retardation. Increases in its incidence may be due to a growing proportion of births to older women who are at higher risk of giving birth to an infant with Down syndrome.

Spina Bifida

Based on data from the Birth Defects Monitoring Program at the Centers for Disease Control and Prevention (CDC), the rate of infants born with spina bifida decreased from 5.2 per 10,000 live births in 1980 to 4.6 in 1991.

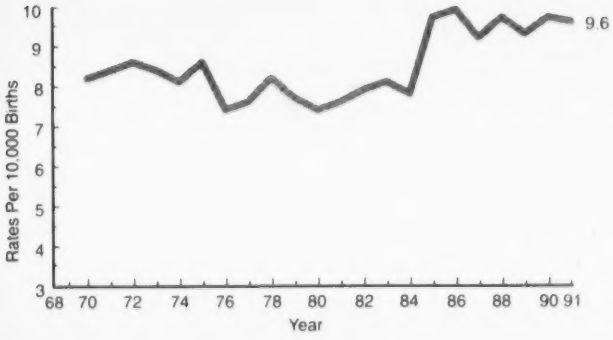
In addition, the proportion of these infants who survive into childhood is increasing each year. Approximately 100,000 infants are born each year in the United States with serious congenital anomalies.

Each year, 1.2 million infants, children, and adults are hospitalized for treatment of anomalies.

Data indicate that in 1990, there were 8,239 infant deaths related to anomalies, accounting for 22% of all infant deaths.

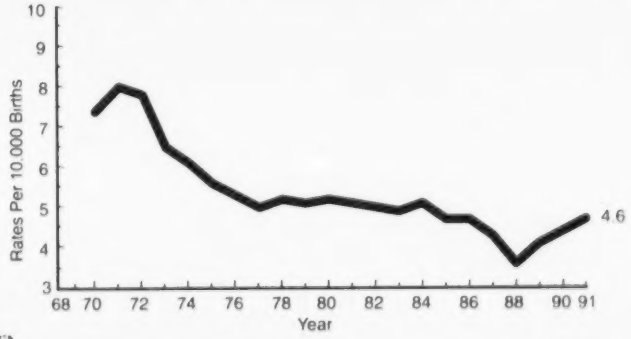
Down Syndrome: 1970 - 1991

Source (II.6): Centers for Disease Control and Prevention



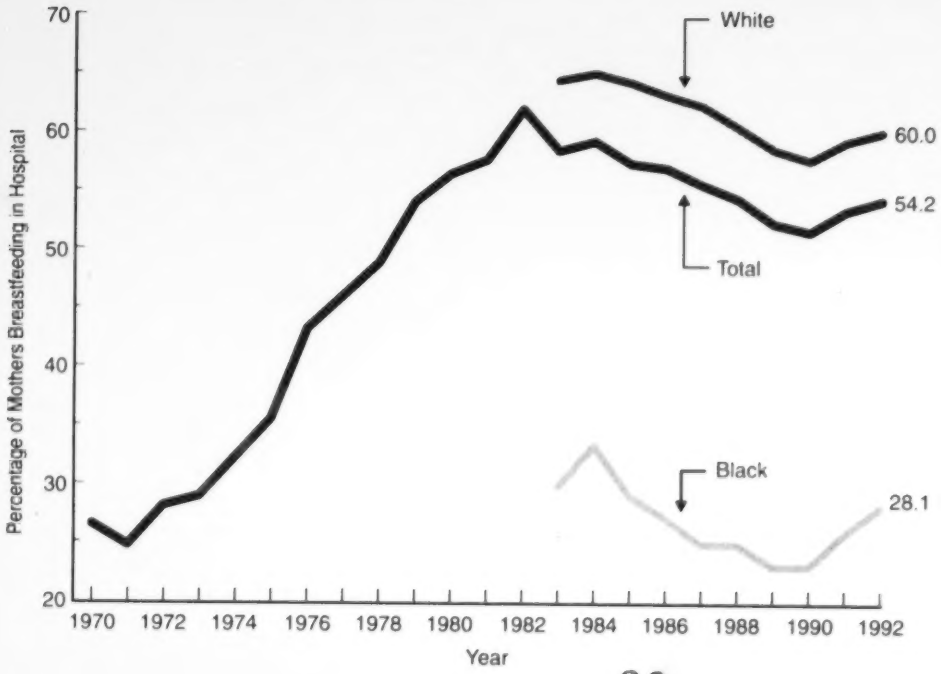
Spina Bifida without Anencephalus: 1970 - 1991

Source (II.6): Centers for Disease Control and Prevention; National Center for Health Statistics



Trends in Breastfeeding by Race: 1970 - 1992

Source (II.7): Ross Laboratories



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INFANT FEEDING

From 1971 to 1982, the percentage of mothers who began breastfeeding in the hospital increased steadily to a high of 62%, but then gradually declined to 51.5% by 1990. Since 1991, however, there has been an increase for both black and white women.

Consistently, the rate of breastfeeding has been more than twice as high for white women as for black women.

Breastfeeding rates for women of all races decrease substantially between delivery and 6 months postpartum. In 1992, only 23.3% of white women and 8.6% of black women were breastfeeding after 6 months.

Breastfeeding rates are highest among women who are older, better educated, relatively affluent, and/or who live in the western United States.

Women least likely to breastfeed are those who have low income, are black, under 20 years of age, and/or who live in the southeastern United States.

CHILD MORTALITY

There were 11,140 deaths of children ages 1-9 years in 1991.

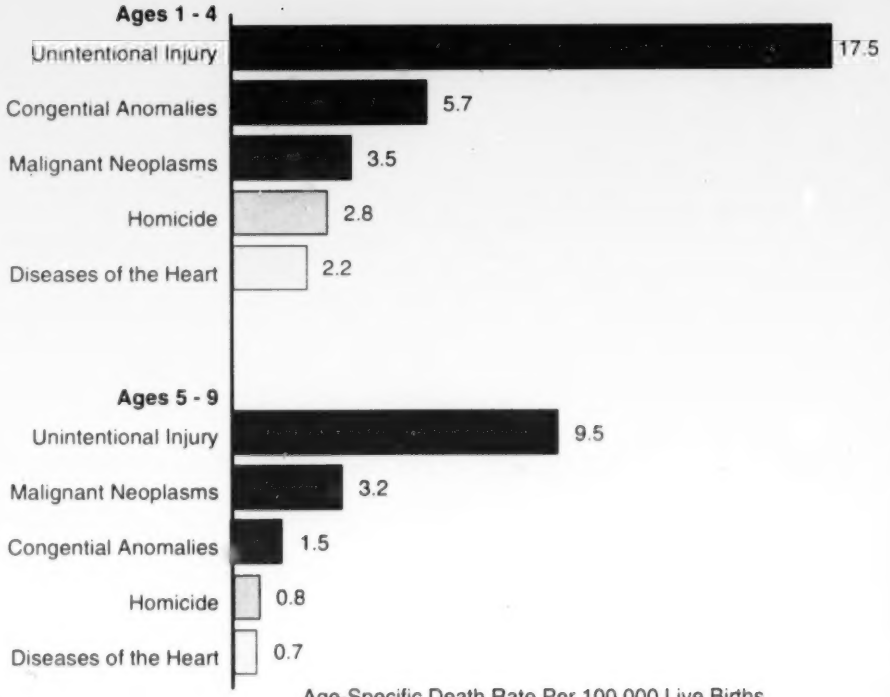
The primary cause of death for children of all ages is unintentional injury, which claimed 4,404 lives among children 1-9 years old in 1991.

During the past several decades, childhood mortality rates have substantially declined.

However, the rate of death due to homicide has nearly tripled since 1960, becoming the fourth leading cause of death of children ages 1-9 years.

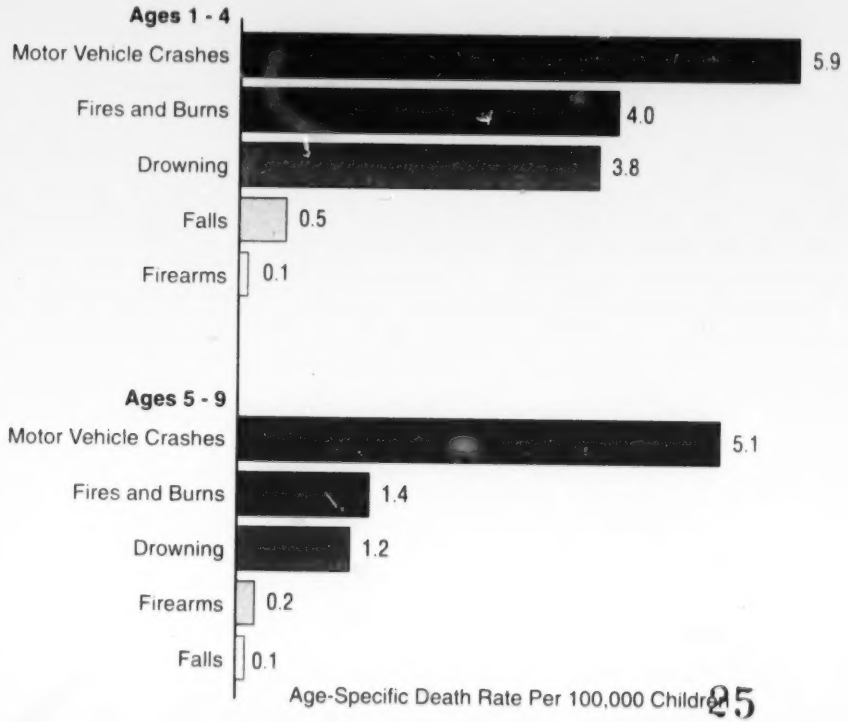
Leading Causes of Death in Children Ages 1-9: 1991

Source (II.8): National Center for Health Statistics



Childhood Deaths Due to Unintentional Injury by Cause and Age: 1991

Source (II 9): National Center for Health Statistics



CHILDHOOD DEATHS DUE TO INJURY

In 1991, there were 2,665 deaths of children ages 1-4 and 1,739 deaths of youngsters ages 5-9 caused by unintentional injuries.

Motor vehicle crashes are the single largest contributing cause of injury death for children 1-9 years old.

Following motor vehicle crashes, fires and related burns and drowning are the leading causes of unintentional injury deaths for children. The death rates from fires and drowning for children ages 1-4 are approximately three times the rate for children ages 5-9.

HOSPITALIZATION

In 1991, there were 3.9 million hospital discharges of children 1 through 21 years old, indicating that there were 5 discharges per 100 children during the year.

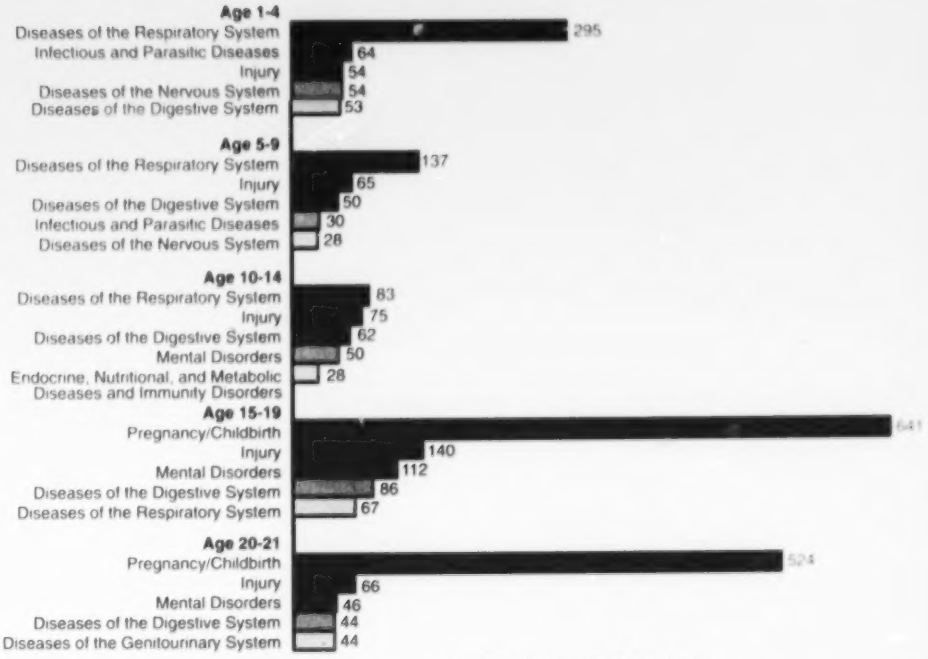
Diseases of the respiratory system were the major cause of hospitalization of children 1-9 years of age and accounted for 36% of their discharges.

Hospital discharge rates decrease with age until age 9 and then increase during later adolescence.

While injuries are the leading cause of death for children older than 1 year, this category accounted for only 11% of the hospital discharges of children 1-14 years in 1991. Pregnancy and childbirth related hospitalizations accounted for 52% of discharges of young women ages 15-21.

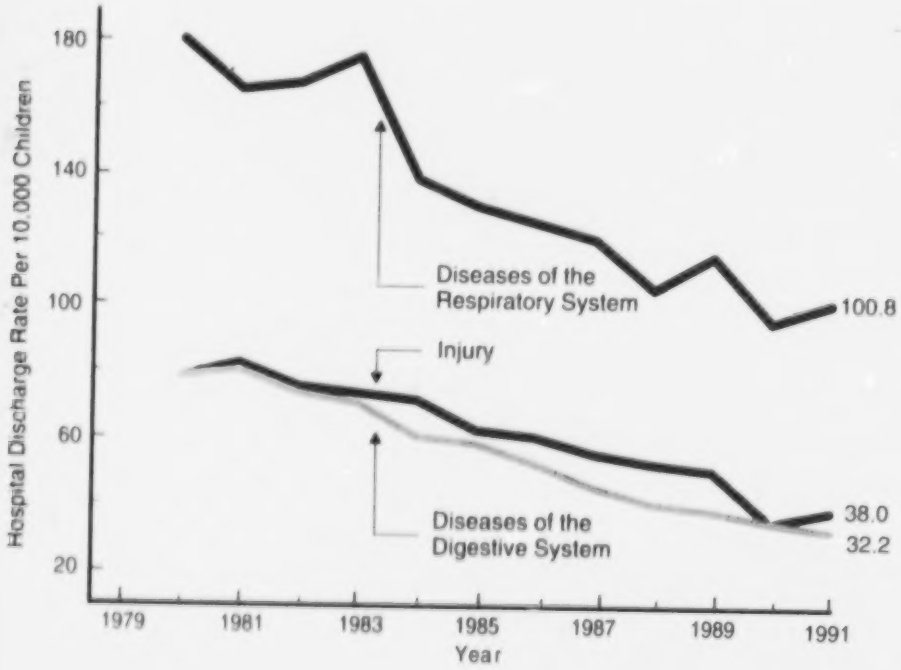
Major Causes of Hospitalization by Age: 1991

Source (II.10): National Center for Health Statistics



Discharge Rate of Patients 1-14 Years Old for Selected Diagnoses: 1980-1991

Source (II 10): National Center for Health Statistics



HOSPITAL DISCHARGE TRENDS

Since 1980, there has been a 44% decrease in overall hospital discharge rates for children aged 1-14 years.

Between 1980 and 1991, there was a 45% decline in the hospital discharge rate for diseases of the respiratory system in children aged 1-14 years.

Three diagnostic categories (diseases of the digestive system, diseases of the respiratory system, and injury) accounted for 52% of the discharges of children aged 1-14 years in 1991.

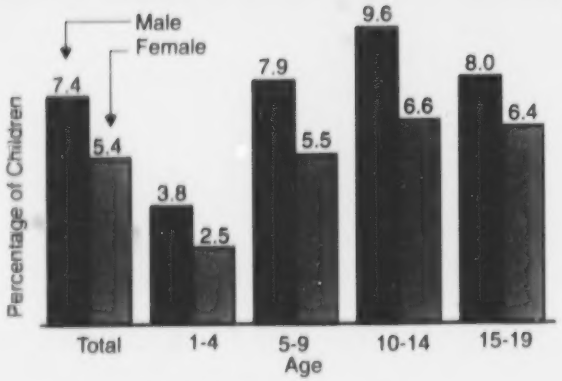
LIMITATION OF ACTIVITY DUE TO CHRONIC CONDITIONS

In 1992, more than 4.3 million (6.5%) children aged 1-19 years were limited in their usual activities because of chronic illnesses and impairments.

The proportion of children with limitation of activity has doubled since 1960. A number of factors may have contributed to this trend, including improved data collection, greater awareness of chronic conditions, greater sensitivity to impairment, and improvements in lifesaving medical technology.

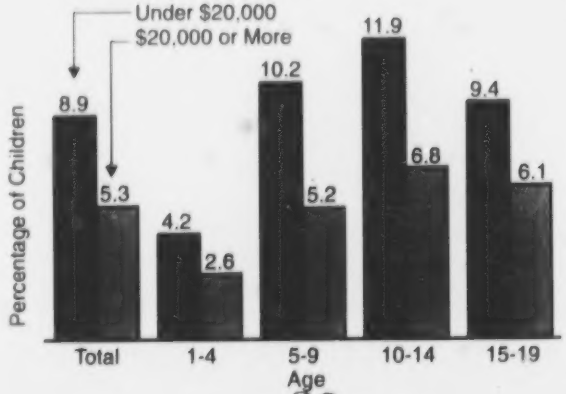
In children younger than 20 years of age, the percentage of males with limitation of activity due to chronic illness is higher than the percentage of females.

Consistently, more children in families with annual incomes below $20,000 were limited in activity due to chronic conditions than were children in families with incomes above $20,000.



Limitation of Activity Due to Chronic Conditions, by Age and Sex: 1992

Source (II 11): National Center for Health Statistics



Limitation of Activity Due to Chronic Conditions, by Age and Income: 1992

Source (II 11): National Center for Health Statistics

LEAD EXPOSURE

The percentage of children with elevated blood lead levels has declined substantially over the last 20 years, with average blood lead levels dropping from 15 to 5 µg/dL. However, in 1990, an estimated 3 million children under age 6 (15%) still had blood lead levels greater than 10 µg/dL.

The most common sources of lead exposure are household paint used in many homes built prior to 1950, dust and soil deposits from leaded gasoline, industrial emissions, and water supplies contaminated by leaded pipes and solder.

Because 10 µg/dL is the level of concern identified by the Centers for Disease Control and Prevention, CDC recommends that primary prevention campaigns--community-wide environmental interventions and nutritional and educational campaigns--should be directed at reducing children's blood lead levels to less than 10 µg/dL. To this end, states have enacted various lead screening and protection statutes. They range from "bare minimum" laws encouraging screening to more comprehensive laws mandating testing and comprehensive follow-up. True "universal" screening of all children has not been required, although a number of states have proposed such a program.

Legally, every state must provide for blood screening for children under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) programs. Some states have limited screening programs targeting certain high-risk populations to determine the extent of the problem in the state. Other states have screening programs that require children to be screened in certain situations such as before entering day care or when visiting a pediatrician.

According to the National Conference of State Legislatures, as of July 1993, 15 states had established screening standards for the testing of some children, often those classified as "high-risk." Twenty-two states have abatement standards, which give the state the authority to require abatement if a child lives in the residence and the lead level is between 10 and 25 µg/dL. Eight states have created a lead task force to contend with lead exposure problems.

Perhaps the most accurate status of lead screening programs is the screening summary of CDC's Childhood Lead Poisoning Prevention Grant Program, since the vast majority of state and local governments use CDC funds exclusively. As of June 30, 1993, 25 states had both current authority for lead screening and utilized CDC funds to provide for their screening programs.

Estimated Percentage of Children Under 6 Years Old With Elevated Blood Lead Levels

Source (II.12): Alliance to End Childhood Lead Poisoning; Centers for Disease Control and Prevention; Environmental Protection Agency

Blood Lead Levels	1976-1980	1990
> 25 µg/dL	10.7	1.0
> 10 µg/dL	91.0	15.0

DENTAL CARIES

Tooth decay has declined dramatically among children during the past two decades. In 1987, a national survey of school children between ages 5 and 17 found that almost one half of them had no tooth decay or fillings in any of their permanent teeth.

Decreases in the incidence of dental decay have been largely attributed to community water fluoridation and the widespread use of fluoride toothpaste.

Despite this general improvement, rural children average slightly more dental decay and missing teeth due to decay than do urban children. According to a 1991 Indian Health Service survey, Native American children average significantly more untreated dental decay than minorities as a whole.

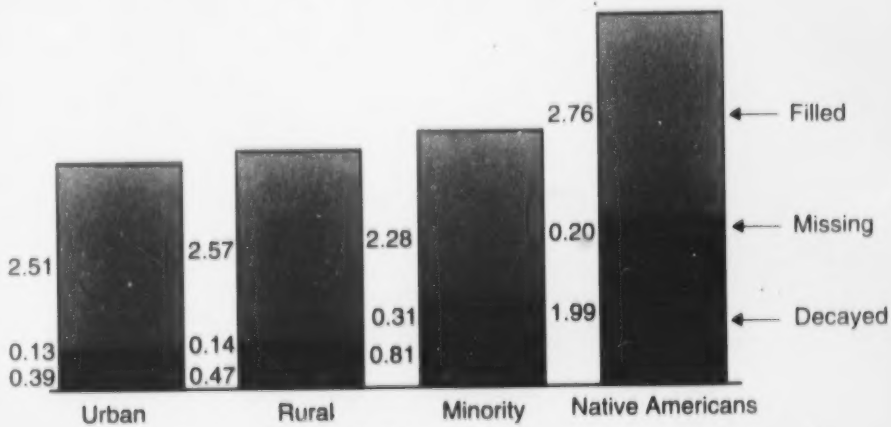
Baby Bottle Tooth Decay

Baby Bottle Tooth Decay (BBTD), attributed to prolonged feeding or sleeping with a bottle containing liquids promoting decay, is an alarming problem among preschool-age children. BBTD often results in the painful and debilitating loss of baby teeth.

Nationally, it is estimated that BBTD afflicts approximately 5% of children ages 2-4 years. However, the prevalence and severity of this condition varies with race, ethnicity, and income level. A study of children ages 3-5 years in Southwestern Head Start Programs indicated that the BBTD prevalence in low-income children is four times that observed in the general population. Among Native American children, BBTD may affect as many as one-third of the preschool-age children in some regions of the country.

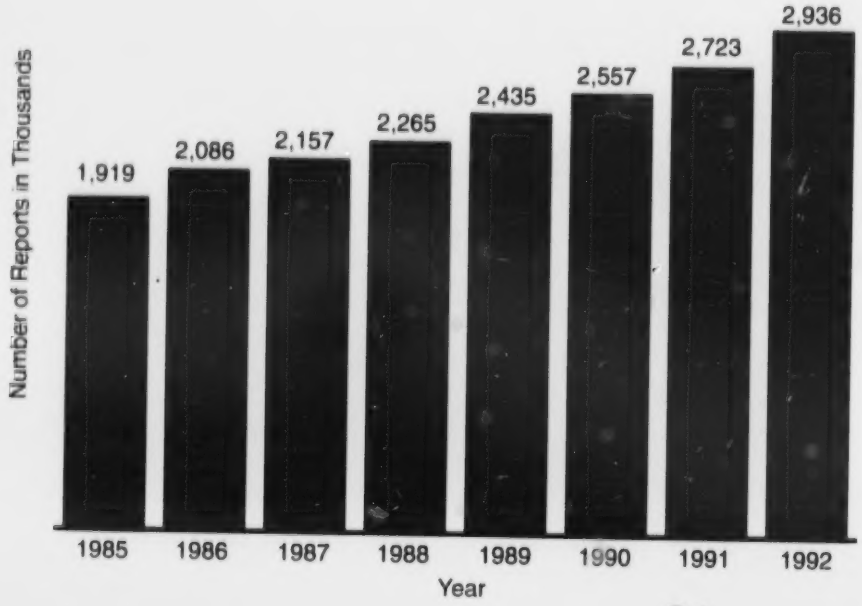
Average Number of Decayed, Missing, and Filled Permanent Tooth Surfaces Per Child Among 5-17 Year Olds: 1991

Source (II.13): Indian Health Service, National Institute on Dental Research, Barnes, et al



National Estimates of Child Abuse and Neglect Reports: 1985-1992

Source (II 14): National Committee to Prevent Child Abuse



CHILD ABUSE AND NEGLECT

There were over 2.9 million children reported as suspected victims of abuse or neglect nationwide in 1992, indicating that 45 of every 1,000 children may have been reported. The rate of children reported in 1992 represents an increase of 50% since 1985.

In 1992, an estimated 1,261 children died from abuse or neglect.

Economic stress and substance abuse are frequently cited as contributing factors to child abuse and neglect. Better recognition of physical and emotional neglect as forms of maltreatment and improved statewide reporting systems may also be related to the recent rise in reporting rates.

Estimates have suggested that between 35% and 50% of reports are substantiated upon investigation.

In 1992, 43% of the substantiated child maltreatment cases involved neglect, 24% involved physical abuse, and 19% involved sexual abuse.

PEDIATRIC AIDS

As of June 30, 1993, 4,710 cases of AIDS in children younger than 13 years of age had been reported in the U.S. This cumulative total included 803 cases reported from July 1992 through June 1993.

Pediatric cases of AIDS represent approximately 1.5% of all cases reported. The majority of pediatric AIDS cases result from perinatal transmission, with a disproportionate number of cases occurring in black and Hispanic children.

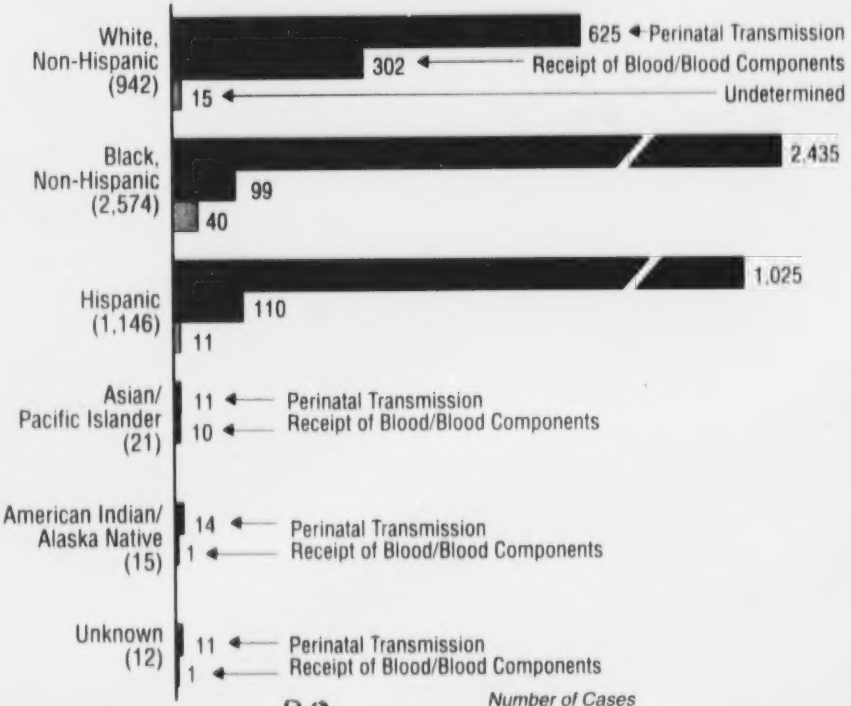
NOTES:

Perinatal Transmission - Child's biologic mother had:
- *Injecting drug use*
- *Sex with injecting drug user*
- *Sex with bisexual male*
- *Sex with person with hemophilia*
- *Born in Pattern-II country*
- *Sex with person from Pattern-II country*
- *Sex with transfusion recipient with HIV infection*
- *Sex with person with HIV infection, risk not specified*
- *Receipt of blood transfusion, blood components, or tissue*
- *Has HIV infection, risk not specified*

Receipt of Blood/Blood Components:
- *Received clotting factor for hemophilia/coagulation disorder*
- *Received blood transfusion, blood components, or tissue*

Pediatric AIDS Cases by Race/Ethnicity and Exposure Category: 1981-June 30, 1993

Source (II.15): Centers for Disease Control and Prevention



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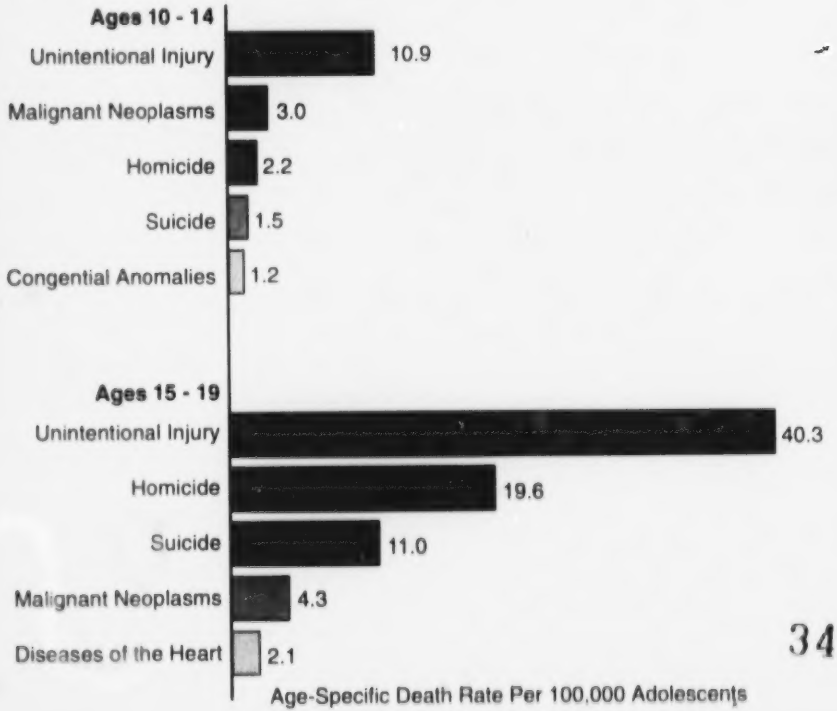
Leading Causes of Death in Adolescents by Age: 1991

Source (II.16): National Center for Health Statistics



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ADOLESCENT MORTALITY

In 1991, there were 19,866 deaths of adolescents aged 10-19 years. In both age categories, the leading cause of death was unintentional injury.

The high rate of unintentional injury death in older adolescents was primarily due to a greater number of motor vehicle crash deaths in this age group.

Homicide is the fourth leading cause of death in children ages 1-9 years. However, for adolescents 10-14 years old, homicide ranks third, and for adolescents 15-19 years old, it is the second leading cause of death.

In 1991, there were 381 homicide deaths among adolescents aged 10-14 and 3,365 homicide deaths of adolescents aged 15-19 years.

The death rate from homicide for black adolescents aged 15-19 is over eight times the rate for whites of the same age. Conversely, the rate of suicide in 15-19 year-olds is almost twice as high in white teens as in black teens.

The death rate for adolescents aged 15-19 declined from 1960-1985, but has increased since 1985. However, death rates from homicide and suicide have been increasing since 1960.

ADOLESCENT DEATHS DUE TO INJURY

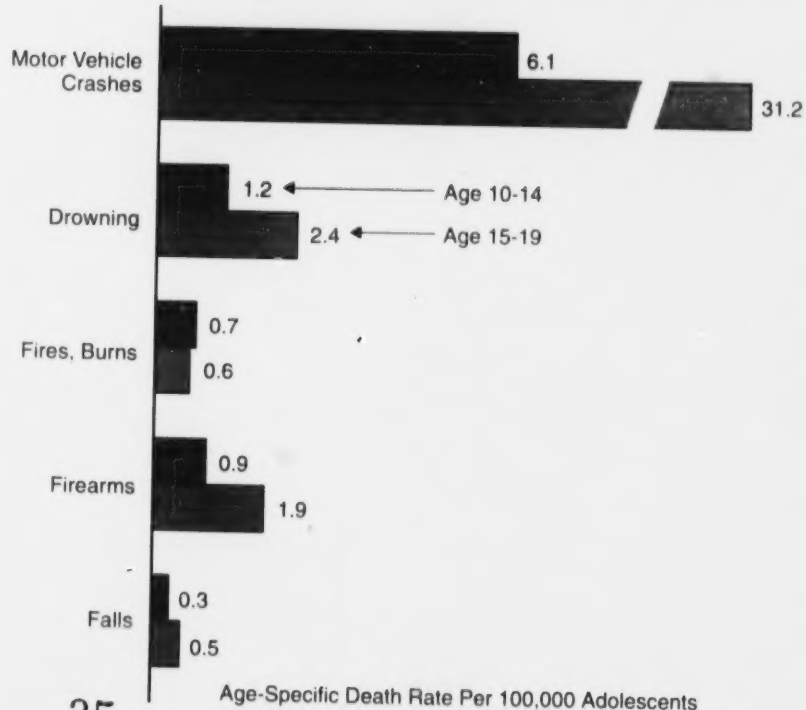
In 1991, there were 1,921 deaths of children 10-14 years old and 6,935 deaths of adolescents 15-19 years old resulting from unintentional injuries.

In both age groups, injuries from motor vehicle crashes were the largest single cause of adolescent mortality.

The motor vehicle crash death rate for adolescents aged 15-19 years was more than three times the rate for all other types of unintentional injuries combined. For 15-19 year olds, the rate of motor vehicle crash deaths for whites was almost twice that for blacks.

Adolescent Deaths Caused by Unintentional Injuries, by Age: 1991

Source (II.17): National Center for Health Statistics



TEENAGE SEXUALITY

Sexual Activity

The percentage of teenage women who were sexually experienced increased from 47% in 1982 to 55% in 1990.

The percentage of teenage women having had sexual intercourse increases with age. In 1990, 41% of 15-17 year-olds were sexually experienced compared with 74% of 18-19 year-olds. These percentages are substantially higher than in 1982, when the figures were 32% and 64%, respectively.

Teen Pregnancy

There were 1,050,040 teenage pregnancies in 1989; of these women, 28,000 were younger than 15. The pregnancy outcomes included 517,989 live births, 389,500 induced abortions, and an estimated 142,550 miscarriages and stillbirths.

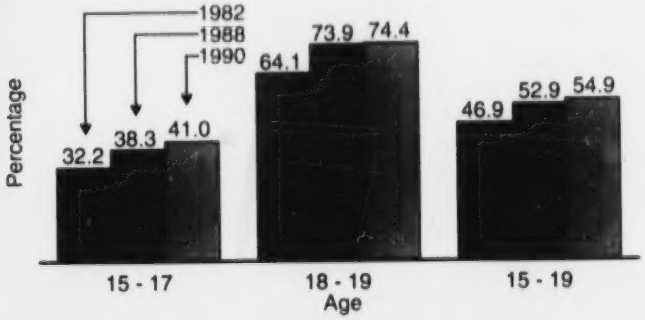
In 1989, 46% of all pregnancies to teenagers under 15 years of age were reported to end in abortion. The percentage of pregnancies ending in abortion decreased with age, to 36% in women 18-19 years of age. Women younger than 20 years old accounted for 25% of all abortions and almost 13% of all births.

Each year, one in every 10 American females aged 15-19 has a birth or abortion, as compared with fewer than one teen in 20 in Canada, England, or France.

The abortion and pregnancy rates in the United States are among the highest of any country that publishes accurate abortion statistics, although certain Eastern European countries for which data are unavailable may have equally high teen pregnancy rates.

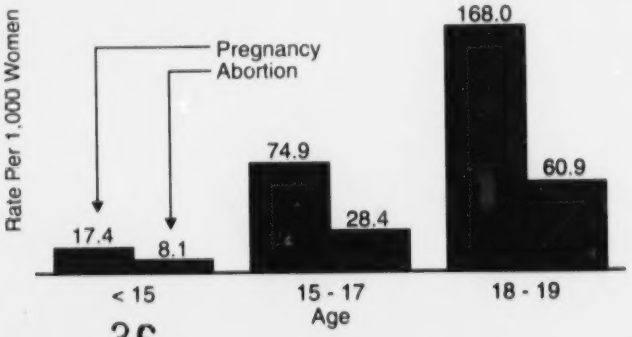
Percentage of Women Ages 15-19 Who Have Ever Had Intercourse: 1982, 1988, and 1990

Source (II.18): National Center for Health Statistics



Rate of Pregnancy and Abortion by Age: 1989

Source (II.18): Alan Guttmacher Institute



CHILDBEARING

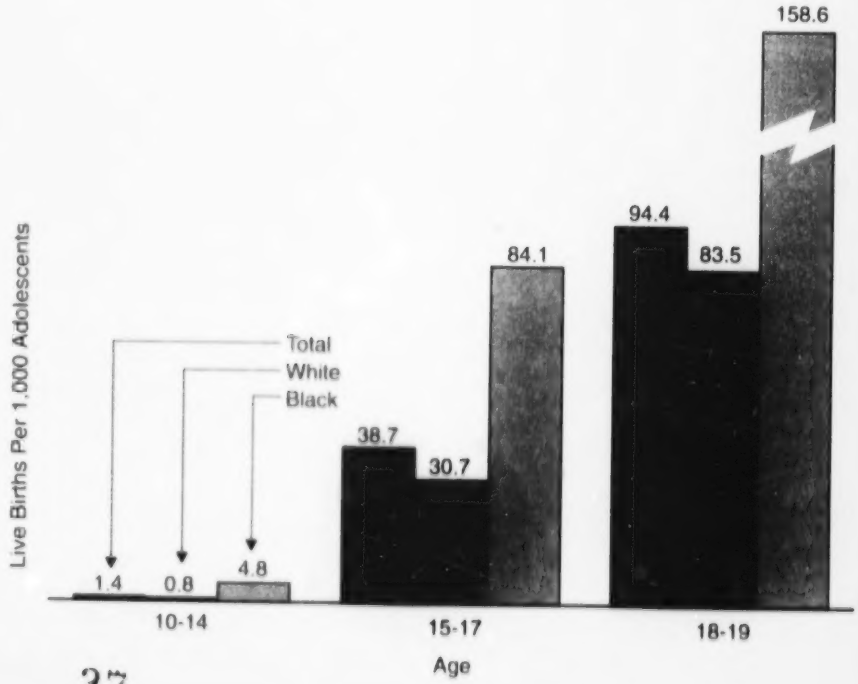
In 1991, the live birth rate per 1,000 individuals was 1.4 for teenagers aged 10-14, 38.7 for those 15-17, and 94.4 for those 18-19 years old.

In 1991, there were 69,990 live births among black females younger than 18 years of age, which represented 10.3% of all births to black women. There were 123,998 births to white females under 18, which represented 3.8% of all births to white women.

In 1991, approximately 59 million women were of childbearing age (14-44 years) in the United States.

Live Births by Age and Race of Mother: 1991

Source (II.19): National Center for Health Statistics



ADOLESCENT AIDS

As of June 30, 1993, 1,301 cases of AIDS were reported in adolescents aged 13 through 19 years. This cumulative total included 428 cases reported from July 1992 through June 1993.*

Males comprised 72% of the 1,301 AIDS cases among adolescents aged 13-19 years. These young men were exposed to HIV primarily through receipt of clotting factor for hemophilia/coagulation disorder. Thirty-eight percent of males aged 13-19 years were exposed to HIV through sexual contact with other males.

Twenty-eight percent of adolescent AIDS cases were among females. Thirty percent of these were sex partners of injecting drug users and an additional 21% admitted injecting drug use themselves.

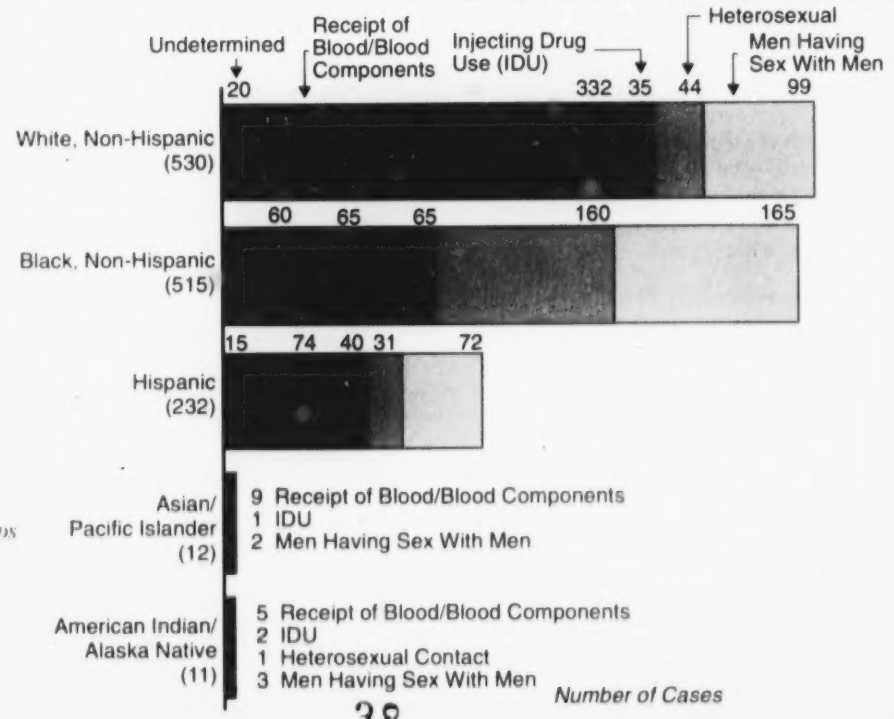
* *Includes six months of data collected under the 1993 expanded AIDS surveillance case definition for adults and adolescents.*

NOTES:

- *Receipt of Blood/Blood Components:*
  Received clotting factor for hemophilia/coagulation disorder
  Received blood transfusion, blood components, or tissue
- *The category "Men Who Have Sex With Men" includes men who have sex with men and who inject drugs.*
- *Race is unknown for one person in this age group.*

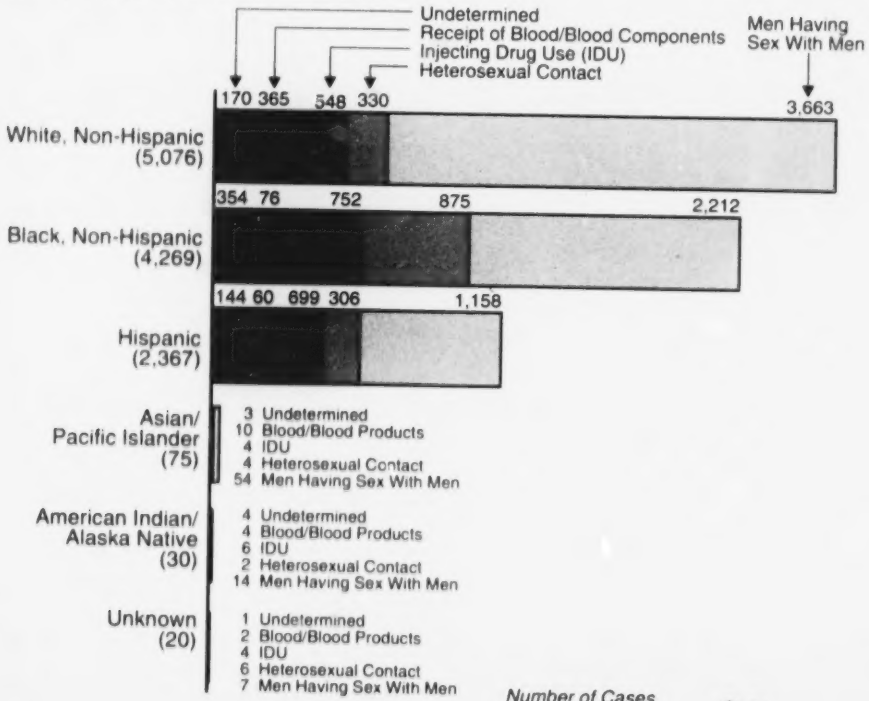
Adolescent AIDS Cases by Race/Ethnicity and Exposure Category for Ages 13-19: 1981-June 30, 1993

Source (II 20): Centers for Disease Control and Prevention



Young Adult AIDS Cases by Race/Ethnicity and Exposure Category for Ages 20-24: 1981-June 30, 1993

Source (II.21): Centers for Disease Control and Prevention



YOUNG ADULT AIDS

As of June 30, 1993, 11,840 cases of AIDS were reported in young adults aged 20-24 years. This cumulative total included 2,945 cases reported from July 1992 through June 1993.*

Across all racial/ethnic groups, men who have sex with men is the major exposure category associated with known AIDS cases in young adults. Young adult women (20% of known AIDS cases in this age group) are exposed to HIV primarily through injecting drug use (35%) or through sex with an injecting drug user (29%).

Due to the long latency period (up to 9 years), the majority of AIDS diagnoses in this age group were most likely the result of infection occurring during adolescence.

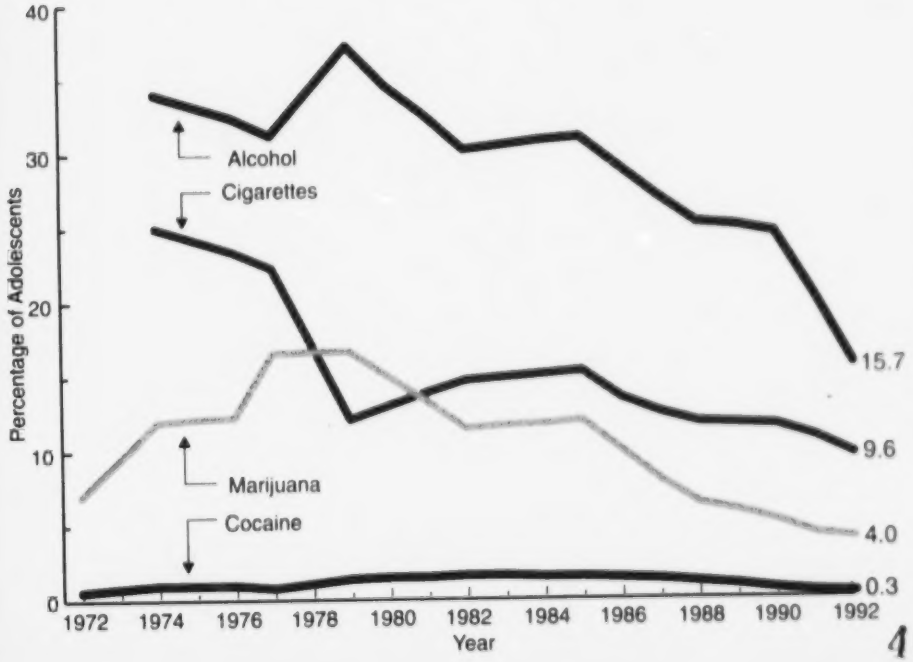
** Includes six months of data collected under the 1993 expanded AIDS surveillance case definition for adults and adolescents.*

NOTES:

- *Receipt of Blood/Blood Components:*
  Received clotting factor for hemophilia/ coagulation disorder
  Received blood transfusion, blood components, or tissue
- *The category "Men Who Have Sex With Men" includes men who have sex with men and who inject drugs*

Use of Selected Substances in the Past Month by Adolescents Aged 12-17: 1972-1992

Source (II.22): National Institute on Drug Abuse



SUBSTANCE ABUSE

Alcohol continues to be the most widely abused substance among youth aged 12-17 years.

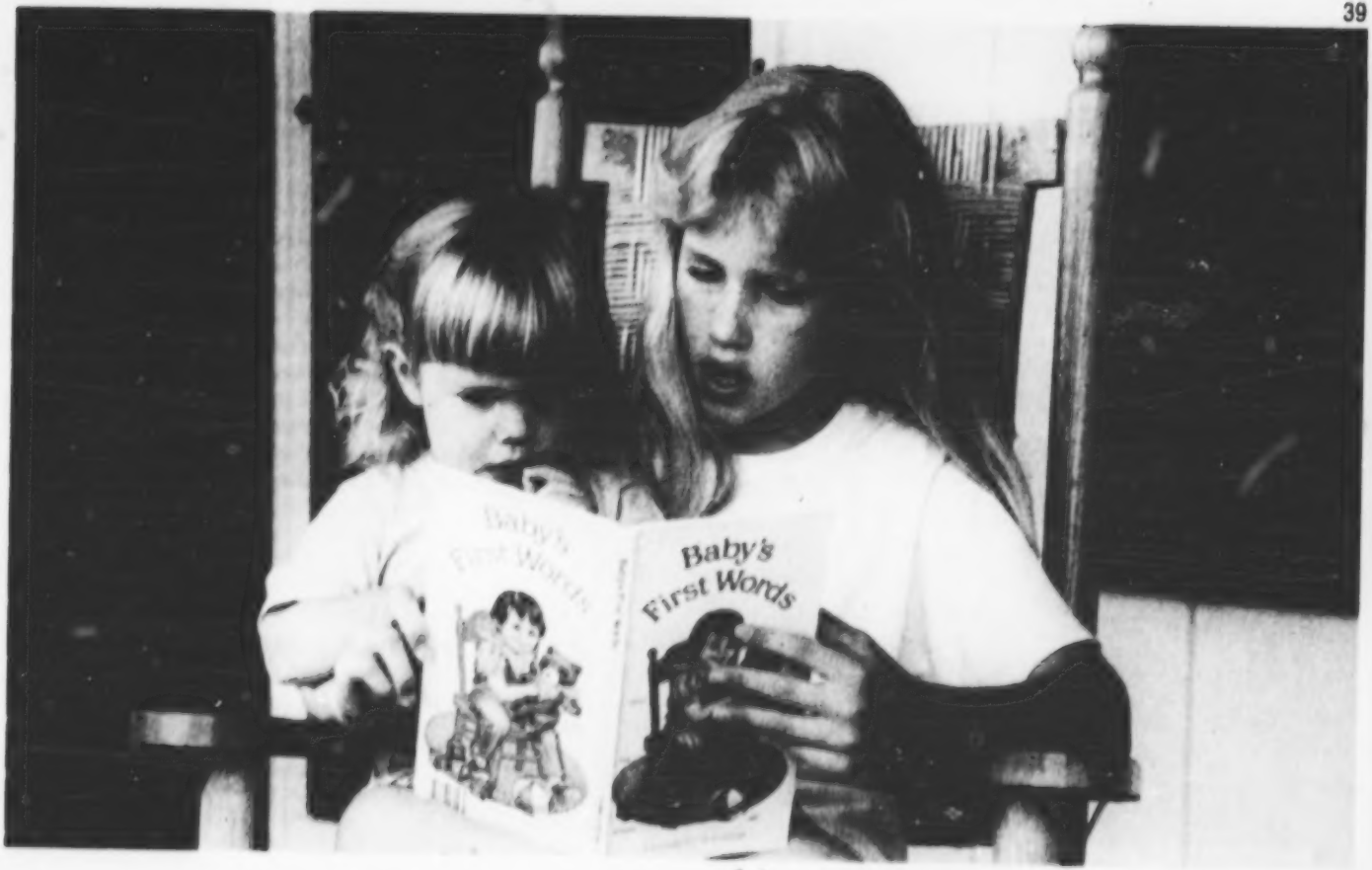
Cigarette smoking has declined steadily over the past decade.

Although the use of marijuana peaked in the late 1970s with 17% indicating use in the past month, there has been an apparent decline in the 1980s and early 1990s. A similar trend has been observed in alcohol consumption.

In the 1992 National Household Survey on Drug Abuse, 11.7% of 12- to 17-year-olds reported using an illicit drug in the past year and 6.1% reported using an illicit drug at least once in the month prior to interview (also called current use).

Percentage of Use in Past Month by Age

	12-13	14-15	16-17
Alcohol	3.8	14.8	29.9
Cigarettes	1.9	9.4	18.1
Marijuana	0.9	3.8	7.8


Baby's
First Words

The availability of and access to quality health care directly affect the health of mothers and children, especially those at high medical and social risk. Until the implementation of Health Care Reform, there is no universal coverage for women and children in the United States. It is estimated that of the 45 million children and women of child bearing age, 19 million do not have health care coverage. Although some private physicians and hospitals provide "free" care, many Americans are still unable to receive needed primary care and preventive services. Many people wait for life-threatening events to occur before they seek care or use hospital emergency room services as their usual source of care. Even the most effective intervention programs are of little value if they are not accessible to those they target. Health Care Reform, with its emphasis on primary and preventive care, should remedy this problem.

This section summarizes recent data on the utilization of health care services by source, type, and place of service.

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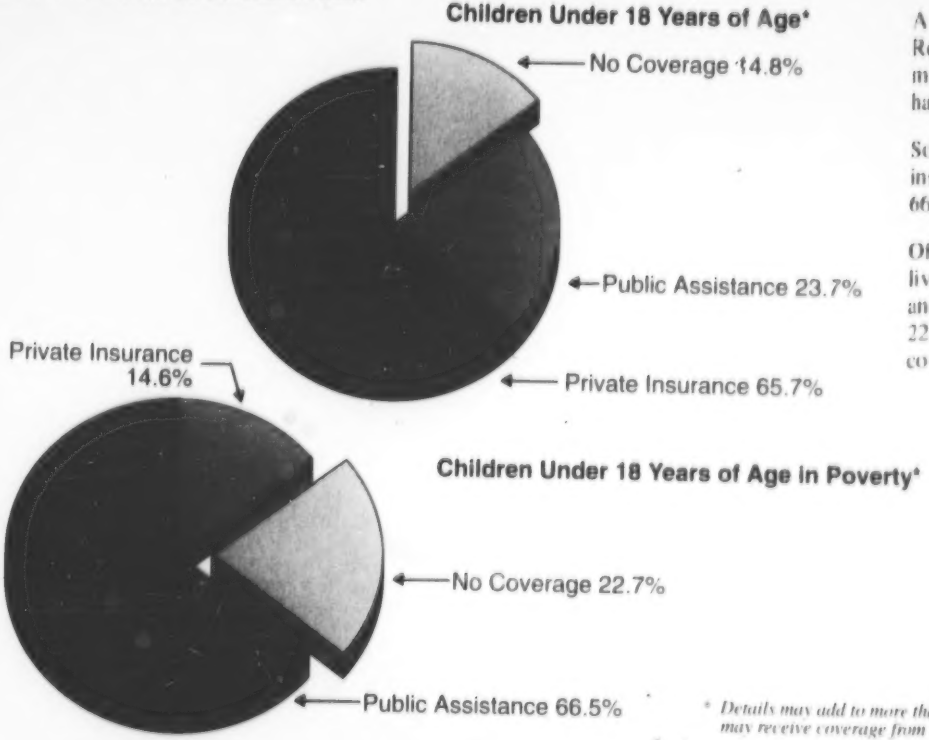
Child Health USA '93

Errata, page 41

Second paragraph should read: Some 23.7% of children were publicly insured, primarily through Medicaid, and 65.7% were covered by private insurance.

Health Insurance Coverage: 1992

Source (III.1): Employee Benefit Research Institute


Children Under 18 Years of Age*
No Coverage 14.8%
Public Assistance 23.7%
Private Insurance 65.7%
Private Insurance 14.6%
Children Under 18 Years of Age in Poverty*
No Coverage 22.7%
Public Assistance 66.5%

* *Details may add to more than 100% because individuals may receive coverage from more than one source.*

HEALTH CARE FINANCING

A 1993 report from the Employee Benefit Research Institute indicated that 14.8% or 9.8 million children younger than 18 years of age had no insurance coverage in 1992.

Some 22.6% of children were publicly insured, primarily through Medicaid, and 66.7% were covered by private insurance.

Of children younger than 18 whose families lived in poverty, 66.5% were publicly insured and 14.6% had private coverage. However, 22.7% of children in poverty had no health coverage in 1992.

IMMUNIZATIONS

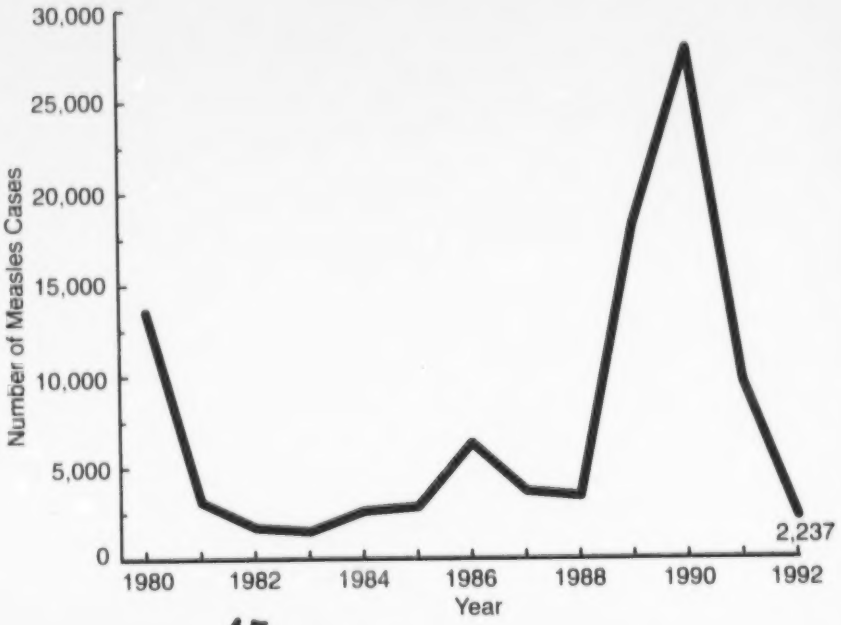
Remarkable progress has been made in the effort to control measles since 1963 when measles vaccines became available for use. Between 1981 and 1982, an average of 3,100 measles cases and two deaths were reported each year. However, in 1989 and 1990, measles cases and deaths rose sharply. During 1989, more than 18,000 cases and 32 deaths were reported. In 1990, more than 27,000 cases and 64 deaths were reported. The increase in the number of measles cases was greatest among children younger than 5 years of age.

Data indicate that in 1991, the number of reported measles cases decreased to 9,643, with 36 deaths, and in 1992, decreased further to 2,237 cases and 3 deaths.

One of the major reasons for the recent measles epidemic is the failure to immunize children at the recommended age of 12-15 months. An increase in measles cases, among the most preventable of the vaccine-preventable diseases, indicates low measles vaccine coverage in some areas of the U.S.

Reported Number of Measles Cases: 1980-1992

Source (III 2): Centers for Disease Control and Prevention; Interagency Committee to Improve Access to Immunization Services; National Vaccine Advisory Committee



Current recommendations call for a child to receive nine different vaccines or toxoids (many in combination form and all requiring more than one dose) in five to seven visits between birth and school entry. While most children have received their immunizations by the time they enter school (more than 95%), many are not vaccinated as early as recommended. Given low immunization levels among young children, it is reasonable to suspect that there are substantial numbers of children now also susceptible to pertussis, poliomyelitis, mumps, rubella, and Hemophilus type B disease.

The U.S. is far from meeting the year 2000 objectives that 90% of all children receive basic immunizations by their second birthday.

Recommended Child Vaccination Schedule of the Public Health Service's Immunization Practices Advisory Committee

Age	DTP[3]	Poliomyelitis[4]	MMR[5]	HIB[1]		HBV[2]	
				Option 1	Option 2	Option 1	Option 2
Birth	-	-	-	-	-	X	-
1-2 months	-	-	-	-	-	X	X
2 months	X	X	-	X	X	-	-
4 months	X	X	-	X	X	-	X
6 months	X	-	-	X	-	-	-
6-18 months	-	-	-	-	-	X	X
12 months	-	-	-	-	X	-	-
15 months	X[6]	X[6]	X[7]	X	-	-	-
4-6 years[8]	X	X	X[9]	-	-	-	-

[1] HIB = Haemophilus b conjugate vaccine. HIB vaccine is given in either a 4-dose schedule (option 1) or a 3-dose schedule (option 2), depending on the type of vaccine used.

[2] HBV = Hepatitis B vaccine. HBV can be given simultaneously with DTP, poliomyelitis, MMR, and Haemophilus b conjugate vaccine at the same visit.

[3] DTP = Diphtheria, tetanus, and pertussis vaccine, combined.

[4] Poliomyelitis vaccine may be live oral polio vaccine in drops (OPV) or killed (inactivated) polio vaccine by injection (IPV).

[5] MMR = Measles, mumps, and rubella vaccine, combined.

[6] Many experts recommend this vaccine at 18 months of age.

[7] In some areas, this dose of MMR vaccine may be given at 12 months.

[8] Before school entry.

[9] Many experts recommend this dose of MMR vaccine be given at entry to middle or junior high school.

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PHYSICIAN VISITS

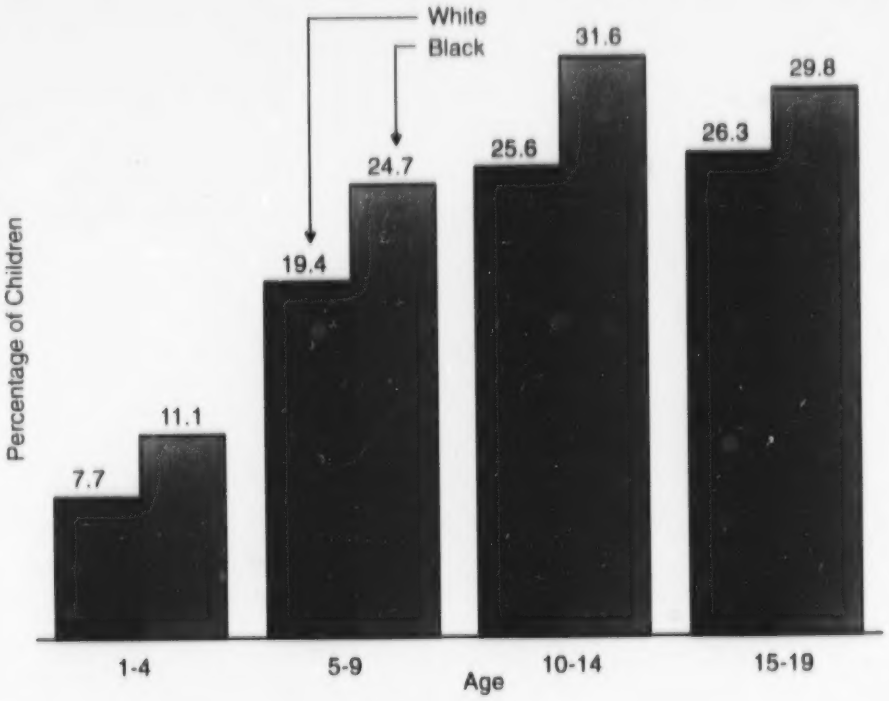
In all age groups, a higher percentage of black children than white children had not been seen by a physician in the past year.

During 1992, 7.7% of white and over 11% of black children ages 1-4 had not been seen by a physician.

In 1992, nearly 22% of children younger than 20 years of age, or 13.6 million children, were not seen by a physician in the past year.

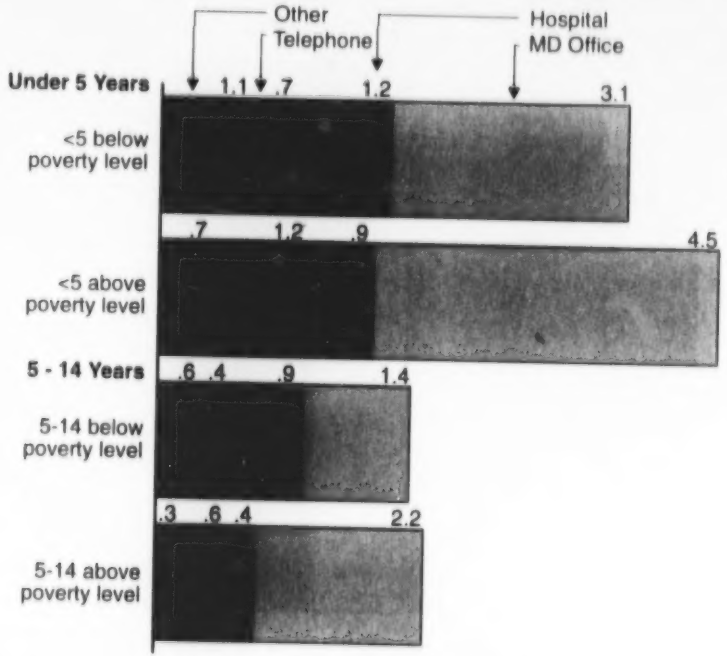
Percentage of Children with No Physician Visits in the Past Year, by Age: 1992

Source (III 3): National Center for Health Statistics



Place of Physician Contact by Age and Poverty Status: 1992

Source (III 4): National Center for Health Statistics



PLACE OF PHYSICIAN CONTACT

Among children who saw a physician during the past year, children younger than 5 years old averaged more physician contacts than school-age children.

Children whose family income was above the poverty level used more physician services than children in poverty.

Children in poverty were more likely to see physicians in hospitals and other places and less likely to see physicians in offices than children above poverty.

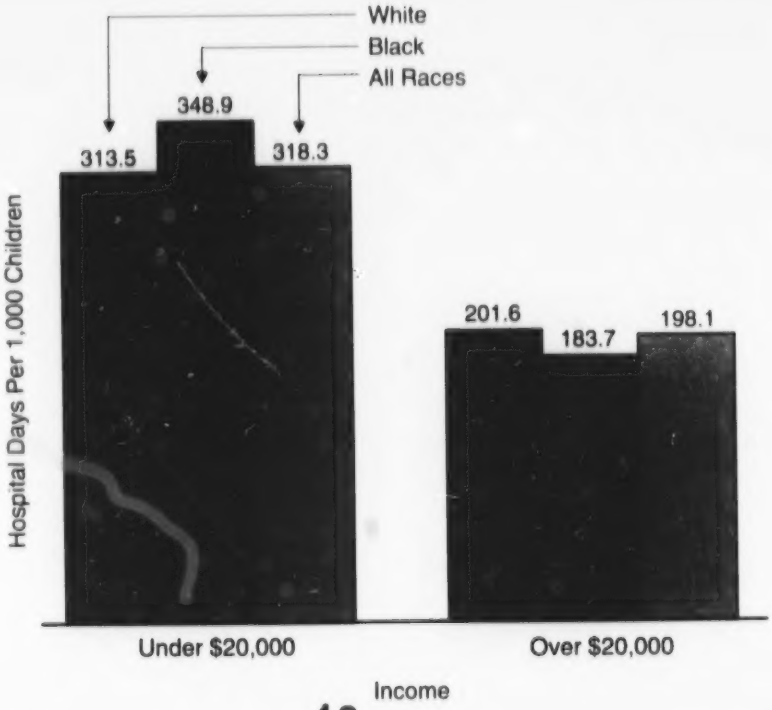
HOSPITAL UTILIZATION

In 1992, children younger than age 18 in families with incomes less than $20,000 averaged 62% more hospital days per 1,000 children than did children from higher income families. This observation suggests that children from poorer families did not receive health care until later in the course of their illness, and as a result, required longer hospitalization.

Although in 1992 white children averaged 10% fewer hospital days than in 1991, black children experienced a 14% increase overall in hospital days.

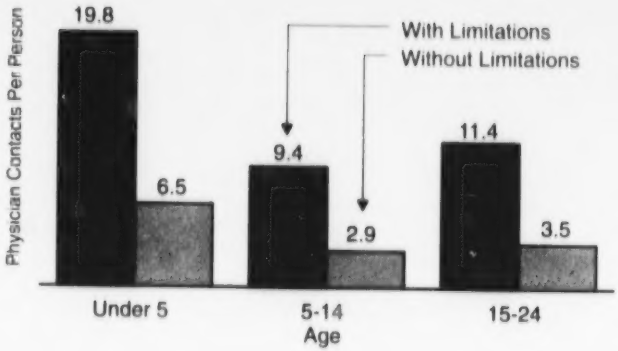
Hospital Utilization by Income and Race: 1992

Source (III 5): National Center for Health Statistics



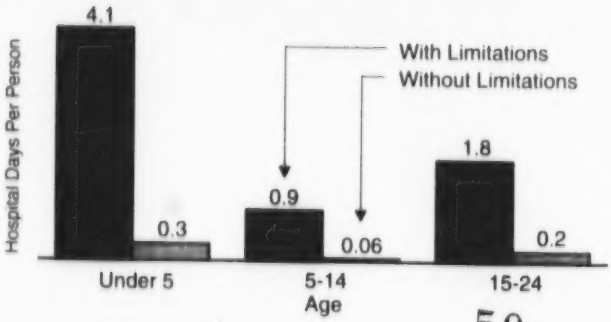
Physician Utilization by Children with Chronic Activity Limitations, by Age: 1992

Source (III.6): National Center for Health Statistics



Hospital Utilization by Children with Chronic Activity Limitations, by Age: 1992 (Excluding Deliveries)

Source (III.6): National Center for Health Statistics



SERVICE UTILIZATION BY CHILDREN WITH CHRONIC CONDITIONS

Physician Utilization

Six percent of all U.S. children have activity limitations; however, this group accounts for 14% of all physician contacts among children.

In 1991, children who were limited in activities had about 2.5 times as many physician contacts as children without chronic conditions.

Hospital Utilization

Children with chronic conditions spend about 10 times as many days in the hospital as children without activity limitations.

Although they represent only 6% of all U.S. children, children with chronic conditions account for 32% of all hospital days among children 1-24 years of age.

DENTAL CARE UTILIZATION

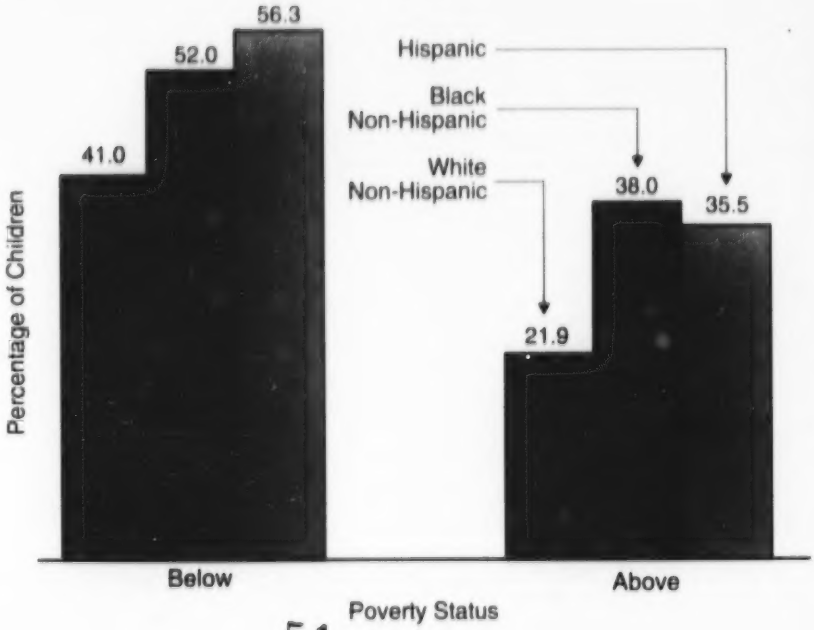
Data from the 1989 National Health Interview Survey indicated that almost 28% of all children aged 5-17 did not have a dental visit in the preceding year. Dental service utilization varied across sociodemographic populations.

Regardless of race or ethnicity, children aged 5-17 years whose families live in poverty are less likely than other children to visit the dentist.

In 1989, more than half of all black and Hispanic children in poverty reported having no dental visit in the past 12 months. About 41% of white, non-Hispanic children in poverty had no dental visit in 1989. On the other hand, nearly 80% of white, non-Hispanic children living above the poverty level reported visiting the dentist at least one time during the past 12 months.

Percentage of Children without a Dental Visit in the Past 12 Months by Race/Ethnicity and Poverty Status: 1989

Source (III.7): National Center for Health Statistics



PRENATAL CARE

Early Prenatal Care

Overall, 76% of all mothers received prenatal care in the first trimester of pregnancy, essentially the same proportion that has been observed since 1979.

There is substantial racial disparity in the timely receipt of prenatal care. In 1991, 79% of white mothers as compared to 62% of black mothers received early prenatal care.

Women younger than 20 years of age are less likely than older women to receive early prenatal care.

No Prenatal Care

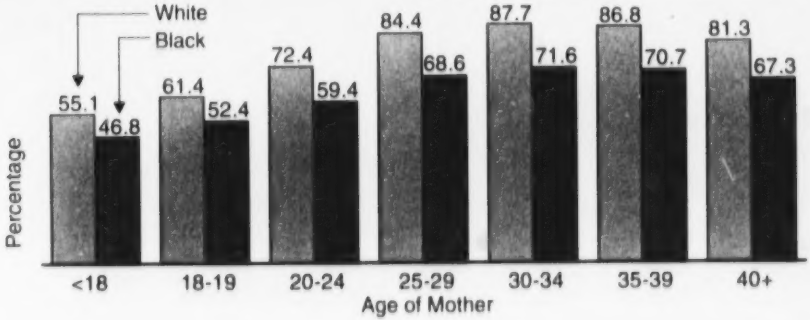
Each year since 1983, 6% of infants were born to mothers who initiated care during the third trimester or received no prenatal care.

Regardless of age, black women are less likely to receive prenatal care than are white women.

Risk factors for not receiving prenatal care include being less than 18 years of age, unmarried status, low educational attainment, and being of minority status.

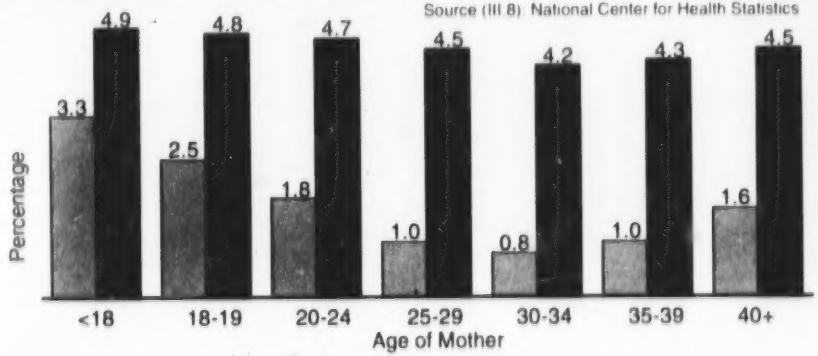
Percentage of Women with Early Prenatal Care, by Age and Race of Mother: 1991

Source (III.8): National Center for Health Statistics



Percentage of Women with No Prenatal Care, by Age and Race of Mother: 1991

Source (III.8): National Center for Health Statistics



Infant and Neonatal Mortality Rates, by Race of Mother and State, 1991, and Perinatal Mortality Rates, by Race of Mother and State, 1990

Source (IV 1): National Center for Health Statistics

State	Infant Mortality[1]			Perinatal Mortality[2]			Neonatal Mortality[3]		
	All	White	Black	All	White	Black	All	White	Black
UNITED STATES	8.9	7.3	17.6	9.1	7.7	16.4	5.6	4.5	11.2
ALABAMA	11.2	8.1	17.3	11.8	9.5	16.1	7.3	5.0	11.8
ALASKA	8.9	7.6	*	6.5	6.4	*	3.5	3.8	*
ARIZONA	8.6	7.8	20.2	8.0	7.5	19.7	5.0	4.5	14.7
ARKANSAS	10.2	8.4	16.4	8.7	7.5	13.0	5.0	4.0	8.4
CALIFORNIA	7.6	7.0	16.6	8.1	7.8	14.8	4.6	4.3	9.5
COLORADO	8.4	7.8	18.2	8.2	7.8	15.2	4.6	4.2	11.7
CONNECTICUT	7.4	6.3	14.7	8.4	7.2	15.8	5.4	4.6	10.7
DELAWARE	11.8	9.7	18.2	10.7	8.3	19.2	7.9	6.8	11.2
DISTRICT OF COL	21.0	*	25.3	20.7	*	24.9	14.9	*	18.3
FLORIDA	9.0	6.7	16.4	9.8	7.8	16.6	5.8	4.4	10.5
GEORGIA	11.4	7.4	18.4	12.0	8.8	17.8	7.5	4.8	12.3
HAWAII	7.4	6.1	32.4	6.9	6.3	*	4.7	4.4	*
IDAHO	8.7	8.6	*	8.5	8.3	*	5.3	5.1	*
ILLINOIS	10.7	7.9	21.3	10.3	8.0	18.4	7.1	5.3	13.7
INDIANA	9.1	7.9	19.3	9.7	9.1	15.3	5.7	4.8	12.8
IOWA	8.0	7.9	*	8.0	7.5	24.6	4.4	4.4	*
KANSAS	8.9	8.0	19.9	7.7	7.3	12.5	5.1	4.5	11.7
KENTUCKY	8.9	8.2	15.5	8.3	7.9	12.7	5.3	5.0	8.3
LOUISIANA	10.5	8.1	14.2	10.6	7.9	14.4	6.6	5.2	8.5
MAINE	6.7	6.7	*	7.0	6.9	*	4.4	4.4	*
MARYLAND	9.2	6.8	14.7	9.7	6.6	16.9	6.0	4.3	10.0
MASSACHUSETTS	6.6	6.1	12.3	7.4	6.9	12.9	4.5	4.2	8.6
MICHIGAN	10.4	7.4	21.6	8.8	6.9	16.0	6.7	4.7	14.2
MINNESOTA	7.5	6.7	22.1	7.7	7.3	18.5	4.4	4.1	11.4
MISSISSIPPI	11.4	7.4	15.5	12.3	8.6	16.5	7.0	4.3	9.8
MISSOURI	10.2	7.9	21.5	8.8	7.6	14.9	6.3	4.9	13.2
MONTANA	7.0	6.0	*	8.2	7.6	*	3.3	3.1	*
NEBRASKA	7.6	6.9	17.9	7.7	6.9	18.0	4.0	3.8	*
NEVADA	9.2	8.2	21.3	8.5	7.8	16.1	4.3	3.7	10.6
NEW HAMPSHIRE	6.1	6.0	*	7.0	7.0	*	3.9	3.9	*
NEW JERSEY	8.7	6.4	18.3	9.5	7.5	17.6	5.7	4.3	11.7
NEW MEXICO	8.1	7.6	*	7.1	7.1	*	5.0	4.8	*
NEW YORK	9.4	7.4	17.5	10.3	8.5	17.8	6.4	5.2	11.8
NORTH CAROLINA	10.8	8.0	17.2	11.1	8.4	17.7	7.1	5.0	11.8
NORTH DAKOTA	8.1	7.2	*	8.6	8.9	*	4.6	4.2	*
OHIO	9.4	7.8	17.8	9.5	8.3	16.1	5.8	4.8	11.2
OKLAHOMA	9.6	9.1	17.4	8.4	8.0	10.4	5.2	5.0	8.3
OREGON	7.3	7.0	20.7	6.9	6.7	*	4.0	3.8	*
PENNSYLVANIA	9.1	7.4	19.4	9.6	8.2	17.5	6.0	4.9	12.6
RHODE ISLAND	8.0	7.0	21.0	7.7	7.8	*	5.6	4.8	*
SOUTH CAROLINA	11.3	8.1	16.4	12.0	8.9	17.3	7.0	4.9	10.5
SOUTH DAKOTA	9.4	8.0	*	9.0	8.0	*	5.4	4.8	*
TENNESSEE	10.0	7.3	18.6	9.6	8.0	15.2	6.2	4.5	11.6
TEXAS	7.7	6.7	14.6	8.0	7.0	13.7	4.5	3.9	8.5
UTAH	6.1	6.0	*	5.6	5.4	*	3.0	3.0	*
VERMONT	5.8	5.9	*	6.3	6.2	*	3.9	3.9	*
VIRGINIA	9.9	7.4	18.3	10.1	7.6	18.1	6.6	4.6	13.0
WASHINGTON	7.5	7.3	14.3	6.9	6.5	15.4	3.9	3.7	9.1
WEST VIRGINIA	8.2	8.1	*	9.7	9.1	26.3	5.0	5.0	*
WISCONSIN	8.3	7.7	14.1	7.6	6.8	14.3	5.0	4.8	7.2
WYOMING	7.9	7.5	*	7.6	7.7	*	3.3	*	*

* *Fewer than 20 deaths, rates not shown.*

1. Rates are deaths less than one year per 1,000 live births in specified group.

2. Rates are fetal deaths ≥ 28 weeks and infant deaths < 7 days per 1,000 live births and specified fetal deaths.

3. Rates are deaths under 28 days per 1,000 live births in specified group.

Percentage of Low Birth Weight Infants, Women Receiving First Trimester Prenatal Care, and Births to Women Under 18, by Race of Mother and State, 1991

Source (IV.2): National Center for Health Statistics

State	Percentage Low Birth Weight			Percentage With Early Prenatal Care			Percentage of Births to Women <18		
	All	White	Black	All	White	Black	All	White	Black
UNITED STATES	7.1	5.8	13.6	76.3	79.5	61.9	4.9	3.8	10.3
ALABAMA	8.7	6.5	13.0	75.3	82.8	61.1	7.2	4.7	11.9
ALASKA	4.7	4.5	7.7	82.3	85.7	82.9	3.5	2.8	4.8
ARIZONA	6.4	6.2	12.8	68.7	70.6	60.9	5.8	5.4	10.9
ARKANSAS	8.2	6.5	13.8	70.5	75.2	54.6	7.5	5.6	14.1
CALIFORNIA	5.8	5.1	12.6	72.8	72.6	70.1	4.5	4.4	7.7
COLORADO	8.2	7.7	15.4	78.6	79.8	65.1	4.4	4.0	10.1
CONNECTICUT	6.9	5.7	14.2	86.4	89.0	69.0	3.2	2.5	7.9
DELAWARE	7.9	5.6	14.5	77.8	84.1	59.3	4.8	2.8	10.7
DISTRICT OF COL	15.4	5.6	17.9	55.2	87.1	50.7	8.1	*	9.7
FLORIDA	7.4	5.9	12.4	74.9	79.6	59.6	5.4	3.7	11.2
GEORGIA	8.6	6.1	12.8	74.5	81.7	62.1	6.7	4.4	10.8
HAWAII	6.8	5.7	11.5	74.5	79.8	74.0	3.7	1.7	*
IDAHO	5.8	5.7	*	74.2	74.5	66.7	4.4	4.4	*
ILLINOIS	7.8	5.7	14.9	77.5	81.7	63.5	5.0	3.0	12.0
INDIANA	6.7	6.0	12.4	77.1	79.8	56.7	5.0	4.1	12.7
IOWA	5.7	5.5	11.1	85.6	86.3	68.0	3.4	3.1	13.0
KANSAS	6.2	5.6	12.1	82.0	83.6	68.0	4.0	3.4	9.9
KENTUCKY	7.2	6.6	12.3	78.4	79.9	64.8	6.5	6.0	11.9
LOUISIANA	9.4	6.1	13.8	75.0	84.7	62.0	7.3	4.3	11.5
MAINE	5.4	5.4	*	84.9	85.1	82.3	3.5	3.4	*
MARYLAND	8.1	5.6	13.3	84.1	89.6	71.5	4.1	2.2	8.2
MASSACHUSETTS	5.9	5.4	10.2	85.8	88.1	69.7	3.0	2.6	6.4
MICHIGAN	7.8	5.8	15.3	79.7	83.9	65.2	4.8	3.1	10.9
MINNESOTA	5.3	4.8	14.6	80.8	83.8	52.4	2.7	2.0	11.6
MISSISSIPPI	9.7	6.5	13.1	73.9	84.8	62.2	9.2	5.5	13.2
MISSOURI	7.5	6.2	13.7	79.1	82.6	62.1	5.2	3.8	12.1
MONTANA	5.6	5.6	*	77.6	79.8	75.6	3.6	3.0	*
NEBRASKA	5.6	5.2	11.7	81.9	83.4	66.4	3.3	2.7	12.3
NEVADA	7.2	6.4	15.3	68.4	70.7	47.7	4.6	4.0	10.2
NEW HAMPSHIRE	4.9	4.8	*	86.1	86.1	66.2	2.1	2.1	*
NEW JERSEY	7.4	5.8	13.7	81.5	85.8	63.1	3.2	2.0	8.7
NEW MEXICO	7.1	7.1	12.9	58.3	60.1	53.7	6.3	6.4	9.2
NEW YORK	7.9	6.2	13.7	73.4	78.7	55.7	3.5	2.7	8.8
NORTH CAROLINA	8.4	6.4	13.1	76.5	83.8	60.4	6.3	4.2	10.9
NORTH DAKOTA	4.8	4.6	*	82.9	85.2	86.9	2.7	2.1	*
OHIO	7.5	6.2	14.3	81.4	84.5	65.3	5.0	3.8	11.4
OKLAHOMA	6.6	5.9	11.8	71.9	75.5	55.7	6.1	4.9	11.9
OREGON	4.9	4.7	12.5	76.8	77.4	66.6	4.4	4.1	13.2
PENNSYLVANIA	7.3	5.8	15.2	79.7	84.5	54.1	4.0	2.8	10.6
RHODE ISLAND	6.0	5.4	12.0	88.9	90.5	76.2	3.6	3.1	8.9
SOUTH CAROLINA	9.2	6.3	13.6	68.8	78.4	53.9	6.7	4.4	10.3
SOUTH DAKOTA	5.4	5.2	*	78.8	82.2	89.3	3.7	2.8	*
TENNESSEE	8.8	6.9	14.8	78.1	82.1	65.8	6.7	5.1	12.1
TEXAS	7.1	6.0	13.3	68.3	69.4	60.1	6.3	5.7	10.6
UTAH	6.0	6.0	13.9	83.3	84.4	71.2	3.7	3.6	*
VERMONT	5.7	5.6	*	83.2	83.3	74.1	2.9	2.9	*
VIRGINIA	7.2	5.6	12.3	80.7	85.9	66.2	4.0	2.7	8.2
WASHINGTON	5.1	4.8	11.2	78.8	80.2	65.5	3.8	3.6	8.4
WEST VIRGINIA	6.8	6.6	13.3	73.5	74.5	48.1	5.9	5.7	11.7
WISCONSIN	6.1	5.2	14.2	81.6	85.4	58.4	3.6	2.2	14.2
WYOMING	7.0	7.0	*	79.3	80.1	63.1	4.3	4.0	*

* *Fewer than 20 occurrences.*

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